HEALTH CARE INDUSTRY

Focus Report on Occupational Injury and Disease

WorkSafe

WORKERS' COMPENSATION BOARD OF BRITISH COLUMBIA

About the WCB

Preventing on-the-job injury and disease is the first priority of the Workers' Compensation Board (WCB) of British Columbia. WCB officers inspect worksites in B.C. to make sure they comply with the Occupational Health and Safety Regulation, which sets out minimum workplace standards for health and safety. The WCB also investigates serious workplace accidents and consults with employers, supervisors, and workers to promote health and safety in the workplace.

Under the requirements of the *Workers Compensation Act*, a worker must report an injury or a disabling occupational disease as soon as possible to the employer. The employer must report work-related injuries, occupational diseases, and work-related deaths to the WCB within three days. A worker may not make an agreement with the employer to give up WCB benefits.

If a worker suffers a work-related injury or illness, the WCB provides fair compensation that may include medical costs, loss of earnings, physical rehabilitation, and pensions. The WCB also works with employers to help injured workers return to work. If a worker is killed on the job, counselling and financial help are made available to the victim's family. For more information on requirements or eligibility for WCB coverage, contact the WCB office nearest you.

WCB Prevention Information Line

The WCB Prevention Information Line can answer your questions about workplace health and safety, worker and employer responsibilities, and reporting a workplace accident or incident. The Prevention Information Line accepts anonymous calls.

Phone 276-3100 in the Lower Mainland, or call 1 888 621-SAFE (7233) toll-free in British Columbia.

To report after-hours and weekend accidents and emergencies, call 604 273-7711.

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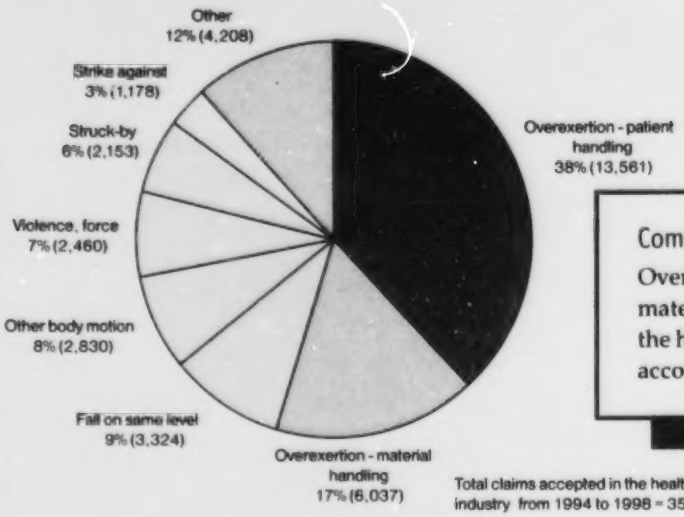

Total claims accepted in the health care industry from 1994 to 1998 = 35,751

Common accident types

Overexertion accidents due to patient handling and material handling were the most common accident type in the health care industry in B.C. from 1994 to 1998. They accounted for 55% of all claims. (See page 12.)

1994–98 claims

For the health care industry as a whole, there was an overall increase in the number of claims, days lost, and claims costs over the five-year period covered in this report. The increases are most apparent from 1996 to 1998. For the same period, there was also an overall increase in the number of person-years of employment. (See pages 10–11.)

Claims data	Totals for 1994–98
Number of time-loss claims	35,751
Number of work days lost	1,568,500
Cost of claims	$155.3 million

1998 claims

In 1998, the injury rate for workers in the health care industry was higher than the provincial injury rate for workers in all industries combined. Claims data on the number of days lost and claims for 1998 are also shown for comparison (figures have been rounded).

Industry	Injury rate*	Days lost	Claims costs
All industries in B.C.	4.8	3,319,300	$601.9 million
Health care industry as a whole	7.4	376,500	$39.3 million
Hospitals and related industries	6.7	255,400	$28.0 million
Nursing home industry	8.9	23,900	$1.9 million
Social services and related industries	9.6	67,600	$6.7 million
Domestics	7.9	29,600	$2.7 million

*The injury rate is the number of time-loss claims accepted by the WCB per 100 workers employed full-time for a year.

Acknowledgments

This report was made possible by the generous assistance of health care industry representatives, organizations, and associations. The Workers' Compensation Board of British Columbia thanks the following organizations, associations, and their representatives who participated in the working group formed to prepare this report:

- British Columbia Nurses' Union
- B.C. Government and Service Employees' Union
- Healthcare Benefit Trust
- Health Employers Association of British Columbia
- Health Sciences Association of British Columbia
- Hospital Employees' Union
- ParaMed Home Health Services
- Simon Fraser Health Region
- United Food and Commercial Workers

The WCB is grateful to the Simon Fraser Health Region for supplying some of the photographs and to the South Fraser Health Region for providing photo opportunities.

The WCB also gratefully acknowledges the many other individuals who participated in the development of this report.

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1 INTRODUCTION

About this report

The statistics in this report make it clear that accidents and injuries on the job are costly. They are costly to employers in terms of lost productivity, disruption to work flow, and claims paid to injured workers by the Workers' Compensation Board (WCB) of British Columbia. They are also costly to workers in terms of pain and suffering, disability, stress, and possible loss or change of employment.

This report profiles the injury claims history of the health care industry in British Columbia from 1994 to 1998. Employers, unions, managers, supervisors, joint health and safety committees, health and safety professionals, and workers will find useful information on injuries and accidents and how to prevent them.

- **Part 1**, the introduction, provides a general overview of the scope of the report, the subclass industries covered in the report, and definitions of the terms used in the report.
- **Part 2** contains an overview of injury claims in the health care industry as a whole.
- **Part 3** gives a statistical profile of the accidents and injuries experienced by workers in hospitals and related industries.
- **Part 4** gives a statistical profile of the accidents and injuries experienced by workers in the nursing home industry.
- **Part 5** gives a statistical profile of the accidents and injuries experienced by workers in social services and related industries.
- **Part 6** focuses on preventing occupational injury and disease. It explains the importance of a commitment to workplace health and safety and an effective occupational health and safety program. It also describes how health and safety records and statistics can be used to pinpoint workplace accident and injury types so that appropriate prevention measures can be implemented.
- **Part 7** tells how to obtain WCB assistance, information, courses, and relevant publications.

Scope of this report

This report covers the five-year period 1994–98 for specific subclass industries, as described below.

The health care industry in British Columbia

For the purposes of this report, the health care industry in British Columbia consists of hospitals and a wide range of related service providers, such as nursing home and home support services. For the reporting period of this report (1994–98), these service providers were registered with the WCB under the following four subclass industries. Note that some firms were registered in more than one subclass industry based on the services they provide.

Subclass industries included in this report

Subclass Industry	CLSBN	Description
Hospitals and related industries	62600	Hospitals, first aid service, health care service
Nursing homes	62605	Nursing homes
Social services and related industries	62608	Social service or health facilities with overnight accommodation and physical assistance (does not include government ministries providing social services)
Domestics	65800	Domestic cleaning, homemaker, and house-sitting services (may include home support)

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Subclass industries 62600, 62605, and 62608 are discussed in detail in this report. Subclass industry 65800 (Domestics) is *not* profiled in this report because health-care-related firms make up only a portion of the organizations registered in this subclass.

Other reports published by the WCB may have selected different subclass industries for health care, resulting in some variation in the statistics among different WCB reports.

Industries not covered in this report

The health care industry covered in this report does not include:

- **62202:** Social service or health facility with overnight accommodation and no physical assistance
- **140605:** Alcohol and drug centres, community service organizations, social rehabilitation centres, social service agencies
- **310101:** Acupuncture services, audiometric testing, chiropractors' offices, clinics, dentists' offices, doctors' offices, hypnotism services, laser therapy services, and offices or establishments for the practice of any of the healing arts or sciences
- **310102:** Dental laboratories, medical laboratories, X-ray laboratories

Information provided in this report

Each of the three subclass industries discussed in this report is considered in a separate section because they vary in terms of number of employees, types of occupations, nature of work performed, and hazards and risks encountered. The following information is presented for each subclass industry:

- Overview of common accident and injury types by occupation
- Injury rate
- Time-loss claims by occupation

For occupations with a statistically significant number of time-loss claims (at least 500 claims in the 1994–98 period), the following information is also presented:

- Yearly numbers of time-loss claims and days lost as a result of all accidents
- Yearly numbers of time-loss claims and days lost because of accident types that accounted for a significant number of time-loss claims
- Injury types resulting from such accidents

Note: *In some tables and graphs, the percentages do not total 100 due to rounding.*

Determining your industry classification

Note that the WCB's industry classification structure has recently been revised. A new industry classification system was implemented January 1, 2000. The following table compares the old and new WCB industry classification system for those parts of the health care industry within the scope of this report.

If you do not know how your firm is classified, check your WCB payroll remittance form or call the WCB Assessments Department at 604 244-6181 or toll-free in B.C. at 1 888 922-2768.

WCB industry classification system

Prior to January 1, 2000		Effective January 1, 2000			
Subclass Industry (CLSIN)	Description	Classification Unit (CU) Code	Classification Unit (CU) Name	Sector	Sub-sector
62600	Hospitals, First Aid Service, Health Care Service	766001	Acute Care	Service Sector	Health Care and Social Assistance
		766004	Ambulance or First Aid Services (Note: Ambulance and First Aid Services are now combined under the same CU code)	Service Sector	Health Care and Social Assistance
		766006	Community Health Support Services	Service Sector	Health Care and Social Assistance
		766019	Short Term Care	Service Sector	Health Care and Social Assistance
62605	Nursing Homes	766011	Long Term Care *	Service Sector	Health Care and Social Assistance
62608	Social Service or Health Facility with Overnight Accommodations and Physical Assistance	766011	Long Term Care *	Service Sector	Health Care and Social Assistance
		766019	Short Term Care	Service Sector	Health Care and Social Assistance

**Intermediate Care is included as a service in the Long Term Care classification.*

Statistics and terminology

Accident statistics at the WCB are based on accepted injury claims from workers. The following terms are used in this report.

Injury rate

The WCB compiles injury rates for various industry groups as well as a provincial injury rate for all industries combined. The injury rate is the number of time-loss claims (short-term disability, long-term disability, and fatality claims) accepted by the WCB per 100 workers employed full-time for a year.

Time-loss claims

Claims discussed in this report are time-loss claims. These include claims where time at work is lost because of a workplace injury that results in a short-term disability (STD), a long-term disability (LTD), or a fatality:

- **STD claims** are those where a payment is made for lost income and the worker is expected to return to work. STD claims involve injuries such as broken arms or back strains.
- **LTD claims** are those where a pension is awarded for a permanent disability, such as the loss of a limb or finger.
- **Fatality claims** are those where a survivor benefit is paid.

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Days lost

Days lost are days that workers do not work as a result of time-loss claims accepted by the WCB. Note that in all the graphs, the number of days lost for a particular year includes days lost in that year as a result of claims accepted both in that year and in previous years, not just claims accepted in that year.

Person-year

A person-year is the equivalent of 52 paid weeks of employment, whether worked by one individual or several. Person-years are estimated based on gross payrolls submitted by employers and matching Statistics Canada wage-rate data. This method of estimating person-years is in accordance with a convention established by the Association of Workers' Compensation Boards of Canada.

Claims cost

Claims cost includes all costs associated with time-loss (STD, LTD, fatal) claims except health care and rehabilitation costs. Claims costs shown in graphs in this report are costs charged in the year regardless of the year of the injury or disease.

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Health care workers

For the purposes of this report, the term *health care worker* includes:

- Nurse aides, care aides, licensed practical nurses (LPNs), and long-term care workers
- Registered nurses (RNs), including psychiatric nurses and nurse supervisors
- Cleaners, housekeepers, and home support workers
- Food preparation workers and kitchen workers
- Clerical workers
- Other workers, such as medical and laboratory technologists and maintenance workers

Counts versus rates

This report presents *counts* of time-loss claims and specific accident types for workers in different occupations. In the report, *injury rate* (number of time-loss claims accepted per 100 workers employed for a year) is calculated for the health care industry as a whole and for the subclass industries, but not by occupation.

Individual organizations and facilities can calculate their own injury rate by occupation if they know the following for each occupation in their workplace:

- Number of person-years of employment
- Number of time-loss claims accepted by the WCB

Injury types

In this report the term *injury types* includes both injuries and diseases (for example, cancer, HIV/AIDS, and tendinitis).

In the graphs the label tendinitis includes tendinitis, tenosynovitis, bursitis, and carpal tunnel syndrome.

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THE HEALTH CARE INDUSTRY

AS A WHOLE

Statistics for 1994–98

From 1994 to 1998, the WCB accepted almost 36,000 time-loss claims for health care workers. The WCB paid more than $155 million for these claims, and more than 1.5 million work days were lost because of work-related injury or disease. Pages 9–14 summarize the performance of the health care industry as a whole during this five-year period.

Overall, the number of claims, number of days lost, and claims costs increased over the five-year period, along with an increase in the number of person-years. These are shown in line graphs on the following pages.

A note about the line graphs in this report

The line graphs show five-year trends for injury rate, number of time-loss claims, number of work days lost, claims costs, and person-years for the health care industry as a whole.

For the statistics to be most meaningful, pay careful attention to definitions, headings, scales, legends, and trends (up, down, no change). This will help you to avoid misinterpreting the information presented and to recognize important relationships. Note that the steeper the trend line, the greater the rate of rise or fall for a given indicator over a given time period.

Be aware that the graphs showing claims for different occupations show *counts* rather than *rates* for time-loss claims. Definitions of terms such as time-loss claims, days lost, and claims cost are given on pages 5–6.

No single statistical report, including this one, will provide you with all you need to know about occupational injury and disease in the B.C. health care industry. Individual employers should therefore maintain accurate and relevant statistics specific to their workplaces. For more information about the importance of records and statistics, see page 74.

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Overall, the number of claims, number of days lost, and claims costs increased over the five-year period, along with an increase in the number of person-years. These are shown in line graphs on the following pages.

A note about the line graphs in this report

The line graphs show five-year trends for injury rate, number of time-loss claims, number of work days lost, claims costs, and person-years for the health care industry as a whole.

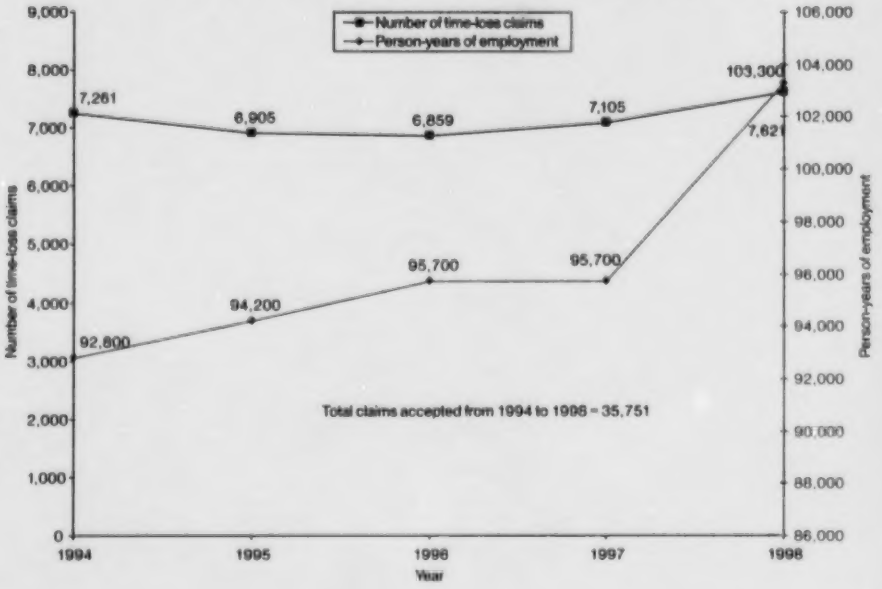
For the statistics to be most meaningful, pay careful attention to definitions, headings, scales, legends, and trends (up, down, no change). This will help you to avoid misinterpreting the information presented and to recognize important relationships. Note that the steeper the trend line, the greater the rate of rise or fall for a given indicator over a given time period.

Be aware that the graphs showing claims for different occupations show *counts* rather than *rates* for time-loss claims. Definitions of terms such as time-loss claims, days lost, and claims cost are given on pages 5–6.

No single statistical report, including this one, will provide you with all you need to know about occupational injury and disease in the B.C. health care industry. Individual employers should therefore maintain accurate and relevant statistics specific to their workplaces. For more information about the importance of records and statistics, see page 74.

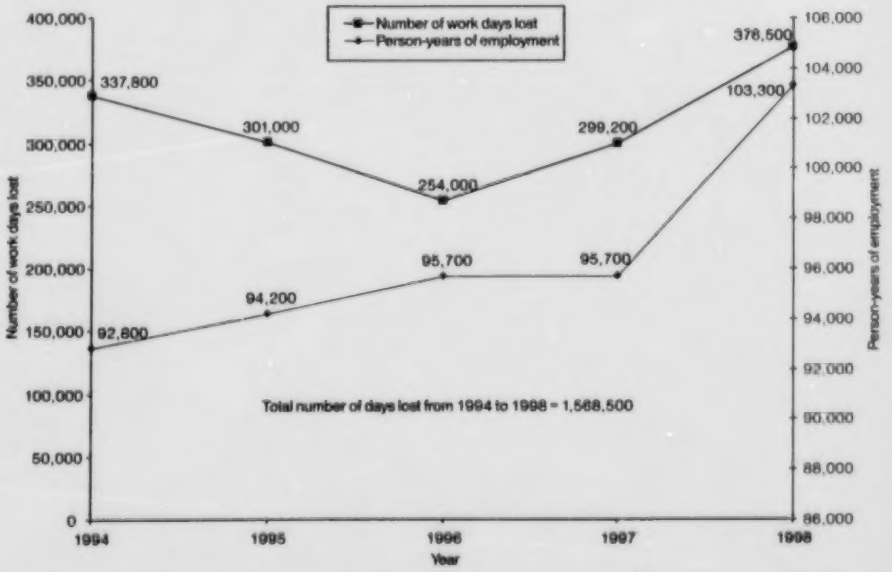
The top line of the time-loss claims graph shows a gradual decrease in the number of claims followed by a gradual increase, for an overall increase of 5% over the five years. The bottom line of all three graphs on pages 10–11 shows that employment in the health care industry increased from 1994 to 1998.The number of person-years increased by 11% during this time, with the sharpest increase (8%) from 1997 to 1998.

Time-loss claims and person-years of employment in the health care industry, 1994–98



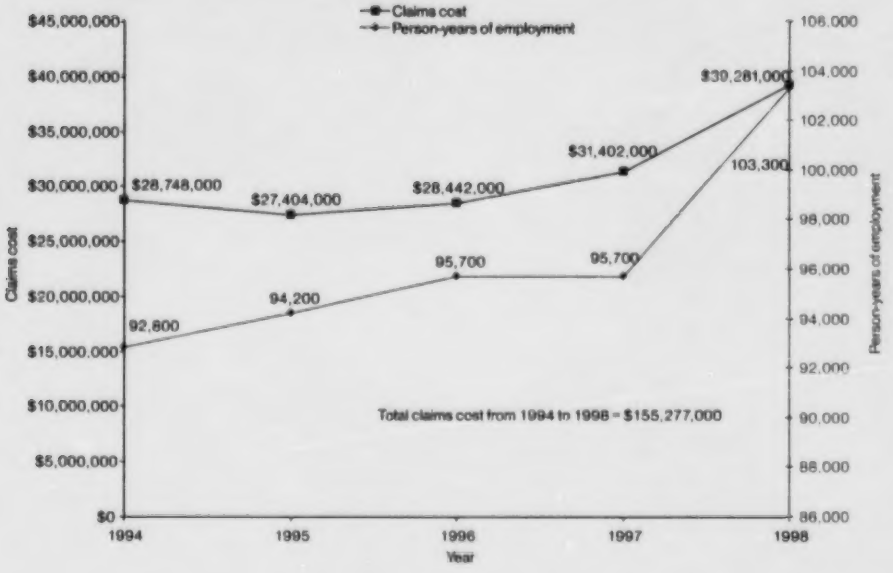
The top line of the days lost graph shows a different trend. The number of days lost decreased from 1994 to 1996 by 25% and then increased from 1996 to 1998 by 48%.

Days lost and person-years of employment in the health care industry, 1994–98



The top line of the claims costs graph shows that costs decreased slightly from 1994 to 1995 and then increased each year from 1995 to 1998, with a sharp rise (25%) from 1997 to 1998. Over the five-year period, claims costs increased by 37%.

Claims cost and person-years of employment in the health care industry, 1994–98



Awkward posture and extended reach are risk factors for musculoskeletal injuries (MSI).

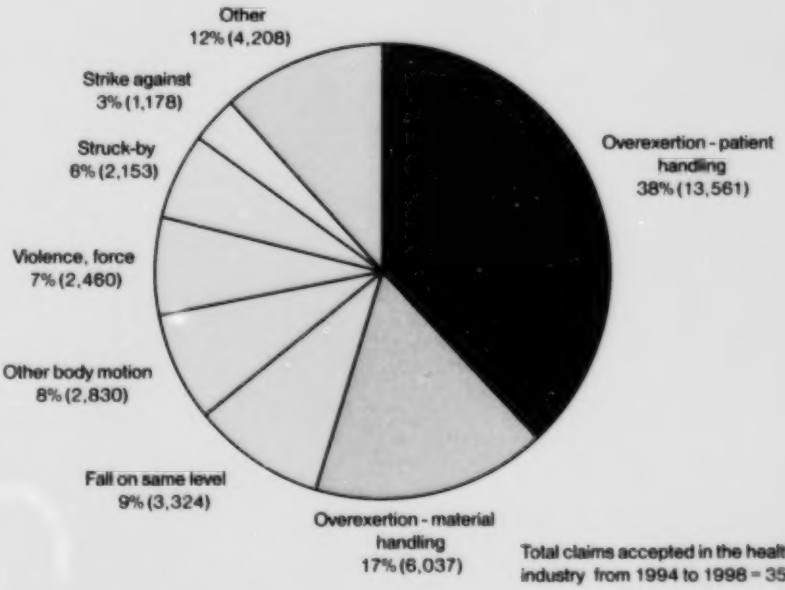
Over the five-year period 1994–98, the most common accident types among health care workers were:

- Overexertion due to patient handling (which accounted for 38% of time-loss claims)
- Overexertion due to material handling (17%)
- Fall on the same level, such as while walking on uneven or rough surfaces (9%)
- Body motion other than repetitive motion (8%)
- Violence, force (7%)

Strains were the most common type of injury, accounting for a total of 73% of all time-loss claims.

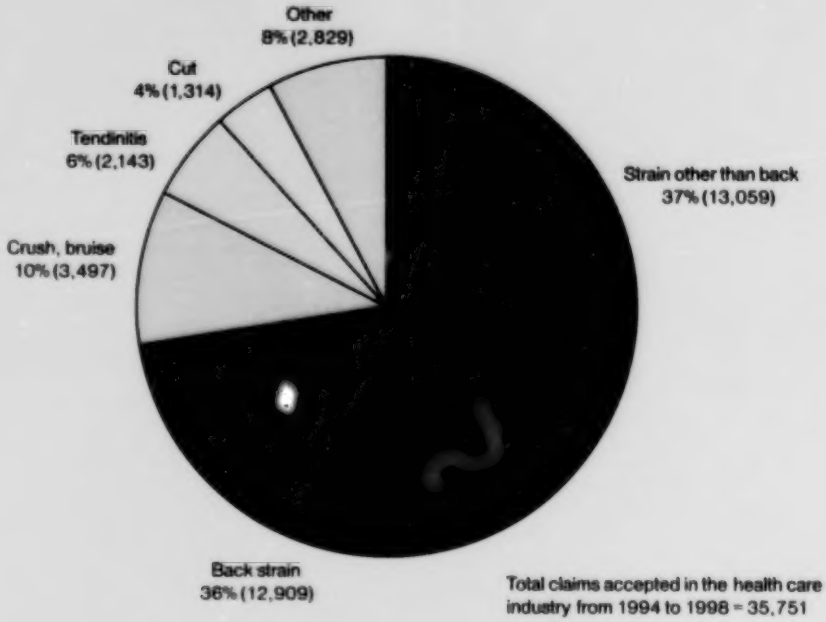
The graphs on pages 12–13 summarize claims statistics for the health care industry as a whole during the 1994–98 period. The table on page 14 lists fatality claims accepted during this period.

Common accident types among workers in the health care industry, 1994–98



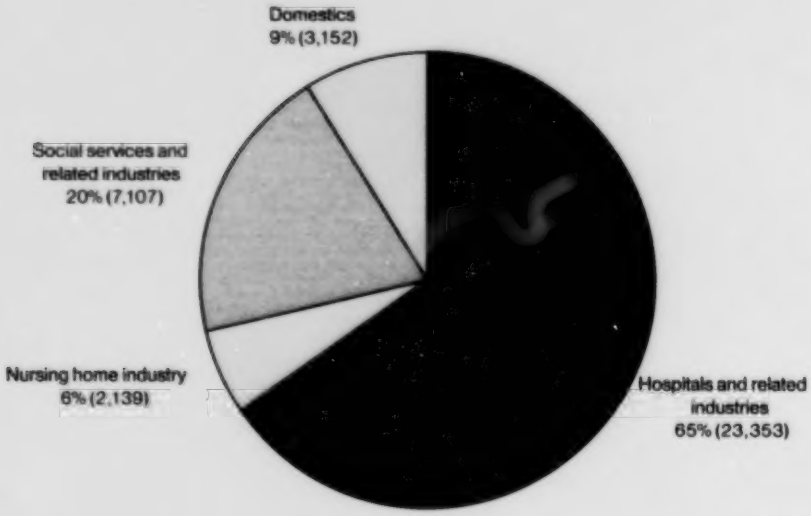
Total claims accepted in the health care industry from 1994 to 1998 = 35,751

Common injury types among workers in the health care industry, 1994–98



Total claims accepted in the health care industry from 1994 to 1998 = 35,751

Claims by subclass in the health care industry, 1994–98



Total claims accepted in the health care industry from 1994 to 1998 = 35,751

Fatalities in the health care industry, 1994–98

Year claim accepted	Age	Occupation	What happened?	Injury/disease
1995	40	Head nurse	Exposure to tuberculosis	Tuberculosis
1996	27	Doctor	Plane crashed en route to an emergency	Multiple injuries
1998	43	Orthotist*	Exposure to various carcinogens	Lung cancer
1998	68	Janitor	Exposure to asbestos	Mesothelioma

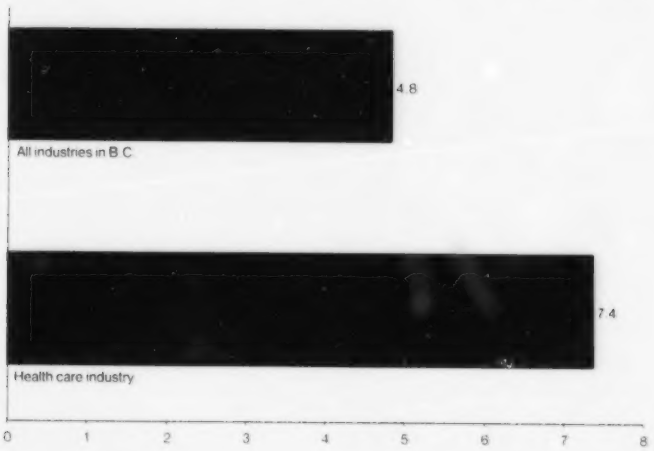
**Person specializing in devices that support, align, correct deformities in, or improve the function of movable parts of the body.*

Statistics for 1998

In 1998, there were approximately 103,300 health care workers in B.C., representing 6.2% of all workers in the province. The occupational health and safety performance of the health care industry relative to all industries combined in that year can be summarized as follows (see pages 5–6 for definitions of terms):

- The **injury rate** for workers in the health care industry as a whole was 7.4. This was 54% higher than the rate for all workers in British Columbia (4.8).
- The WCB accepted 7,621 **time-loss claims** from workers in the health care industry, representing 10.5% of all time-loss claims accepted by the WCB from all workers in B.C.
- Workers in the health care industry accounted for 376,523 **days lost** to injury, representing 11.3% of days lost to injury by all workers in B.C.
- There were two **fatalities** among workers in the health care industry, representing 1.6% of fatalities among all workers in B.C.
- The cost of claims paid by the WCB to health care workers totalled approximately $39.3 million, representing 6.5% of the claims cost paid by the WCB to injured workers in B.C.

Injury rates for the health care industry as a whole and for all industries in British Columbia, 1998



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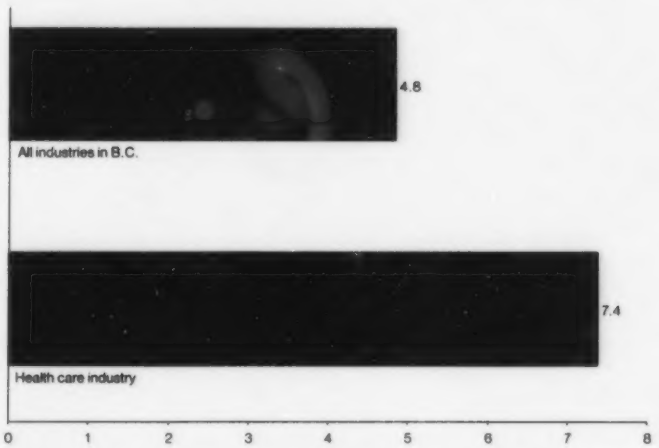


HOSPITALS AND RELATED

INDUSTRIES

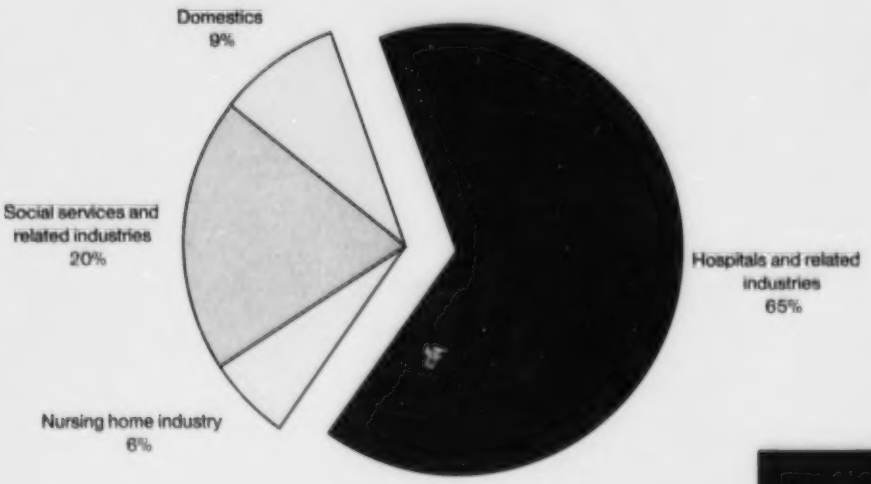
(Subclass Industry 62600)

Overview

Subclass industry 62600 includes hospitals, first aid service, and some other health care services such as community health nursing. The vast majority of workers in this industry are hospital workers.

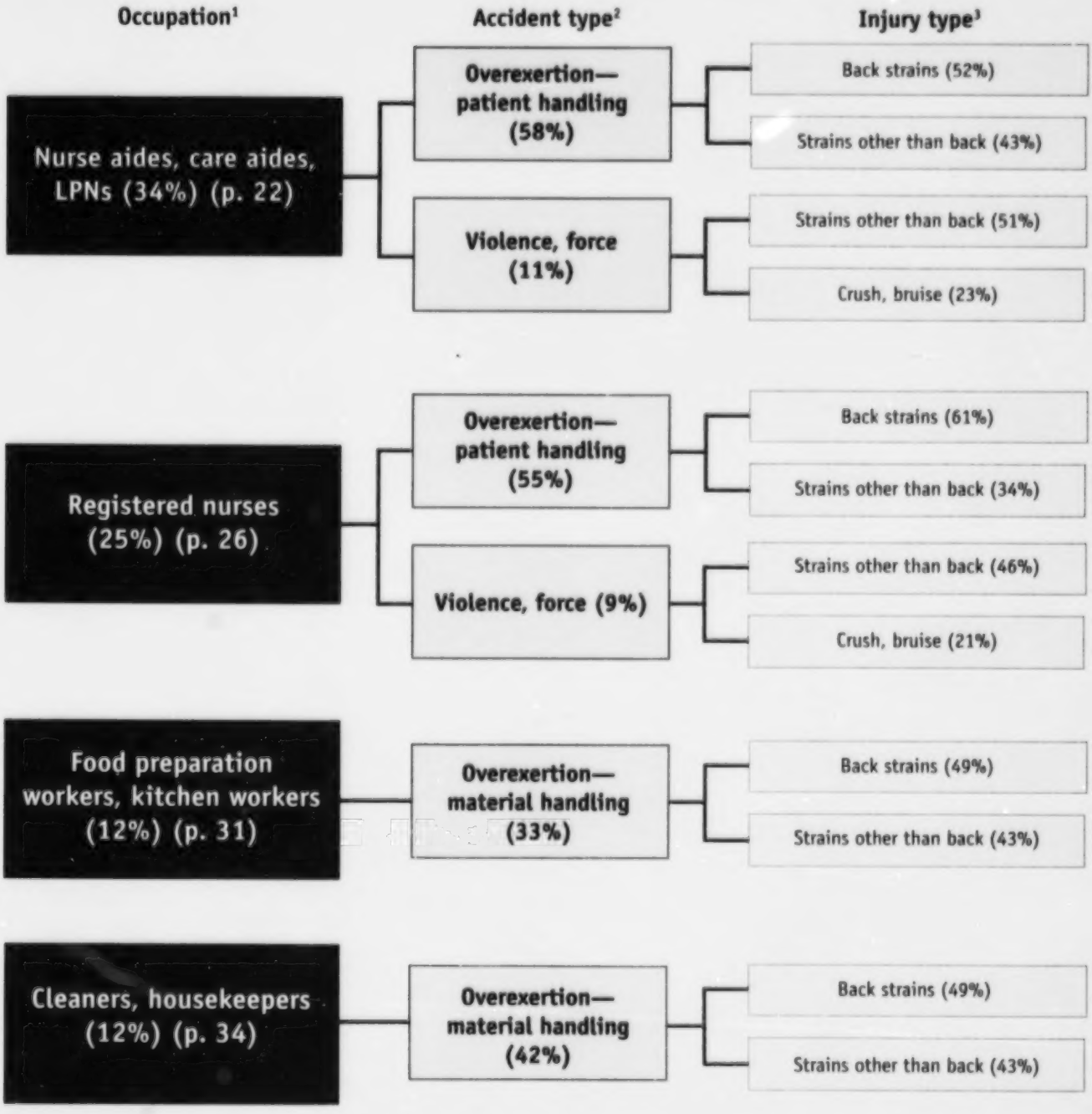
From 1994 to 1998, there were 35, 751 time-loss claims from the health care industry as a whole. Of these, 65% involved workers in hospitals and related industries, as shown in the following graph.

Percentage of claims by subclass industry, 1994–98



The following chart summarizes the occupations, accident types, and injury types that accounted for most of the time-loss claims from workers in hospitals and related industries from 1994 to 1998.

Summary of claims in hospitals and related industries



[1] *The percentages shown are the percentages of all time-loss claims attributable to given occupation categories in hospitals and related industries.*

[2] *The percentages shown are the percentages of time-loss claims attributable to the top one or two accident types for given occupation categories.*

[3] *The percentages shown are the percentages of time-loss claims attributable to the top two injury types for given accident types.*

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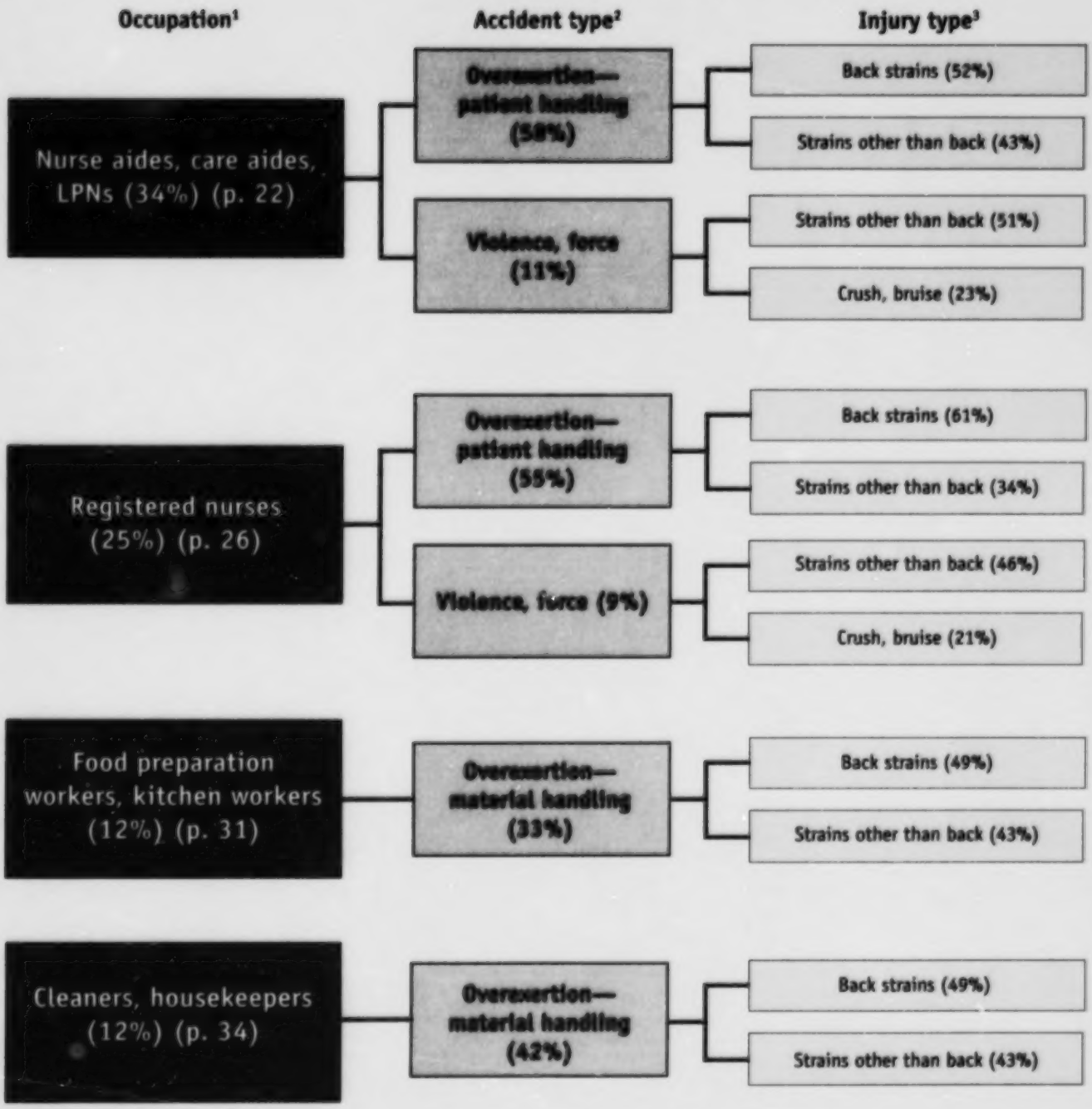

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[2] *The percentages shown are the percentages of time-loss claims attributable to the top one or two accident types for given occupation categories.*

[3] *The percentages shown are the percentages of time-loss claims attributable to the top two injury types for given accident types.*

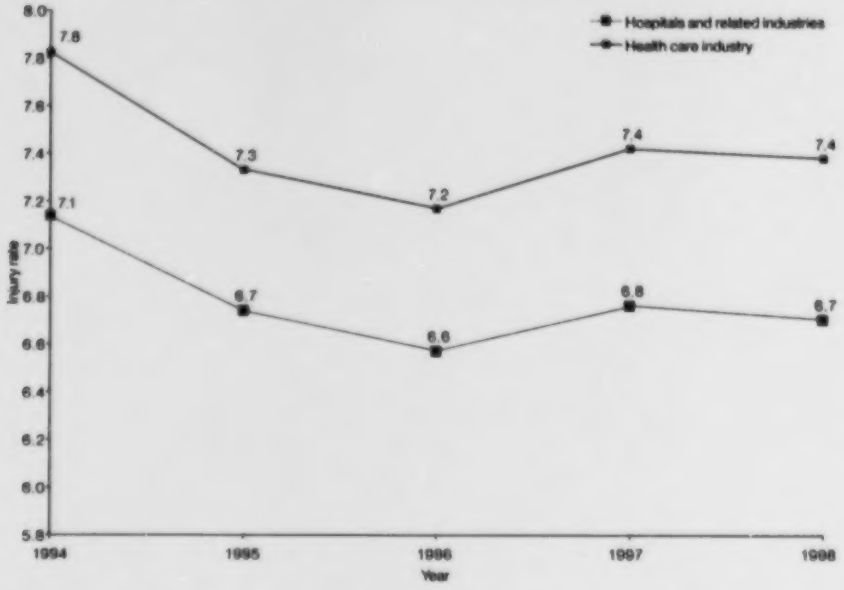
Injury rate

The graph below shows the annual injury rate based on time-loss claims accepted by the WCB for all workers in hospitals and related industries for the 1994–98 period. It also shows the corresponding injury rate for workers in the health care industry as a whole.

From 1994 to 1998, a total of 23,353 claims were accepted from workers in hospitals and related industries, resulting in an average injury rate of 6.8. From 1994 to 1998, time-loss claims resulted in 1,059,605 days lost and $111,808,391 in claims costs.

In 1998, the injury rate for workers in this subclass industry was 6.7. This was 9% lower than the injury rate for workers in the health care industry as a whole (7.4), but 40% higher than the rate for all workers in British Columbia (4.8).

Injury rates: Hospitals and related industries compared with the health care industry as a whole, 1994–98



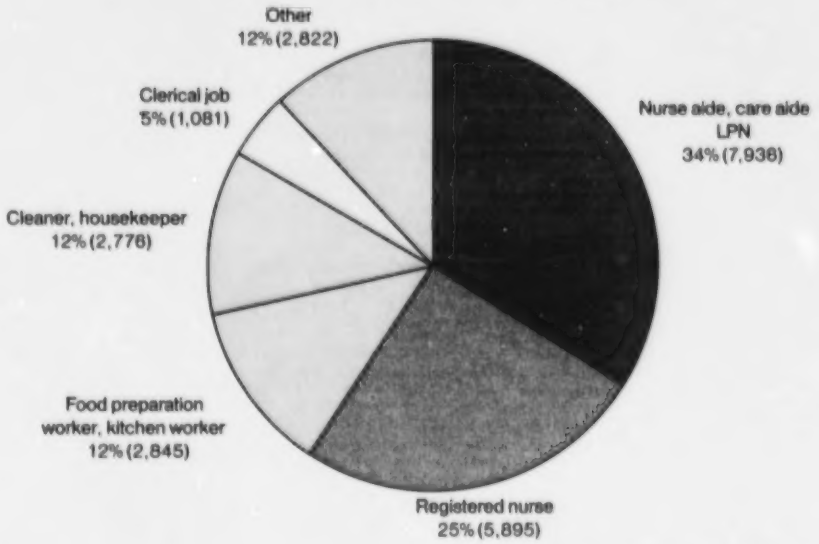
Claims by occupation

The pie graph below shows which occupations in hospitals and related industries accounted for the 23,353 time-loss claims accepted from 1994 to 1998. Four occupation categories accounted for 83% of all these claims:

- Nurse aide, care aide, LPN (34%)
- Registered nurse (25%)
- Food preparation worker, kitchen worker (12%)
- Cleaner, housekeeper (12%)

None of the individual occupations belonging to the "other" category accounted for more than 2.5% of the time-loss claims.

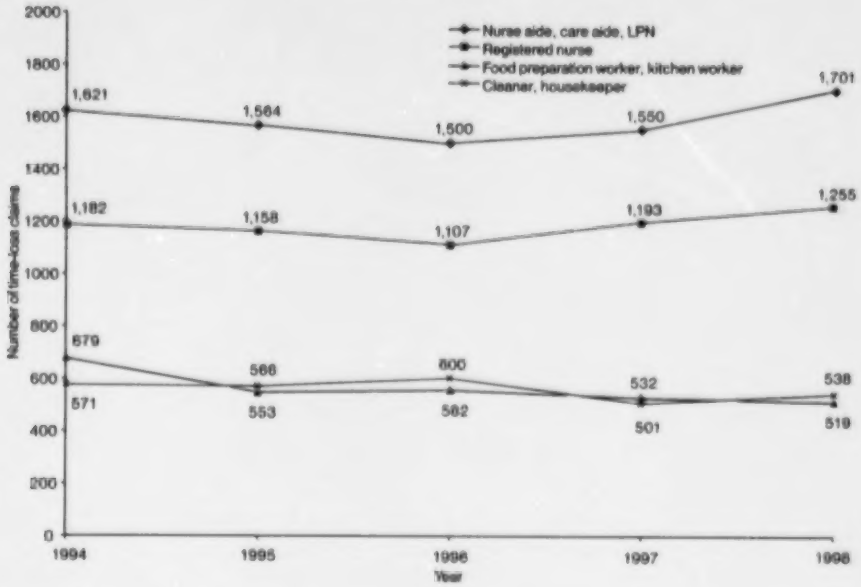
Percentage of claims in hospitals and related industries, by occupation, 1994–98



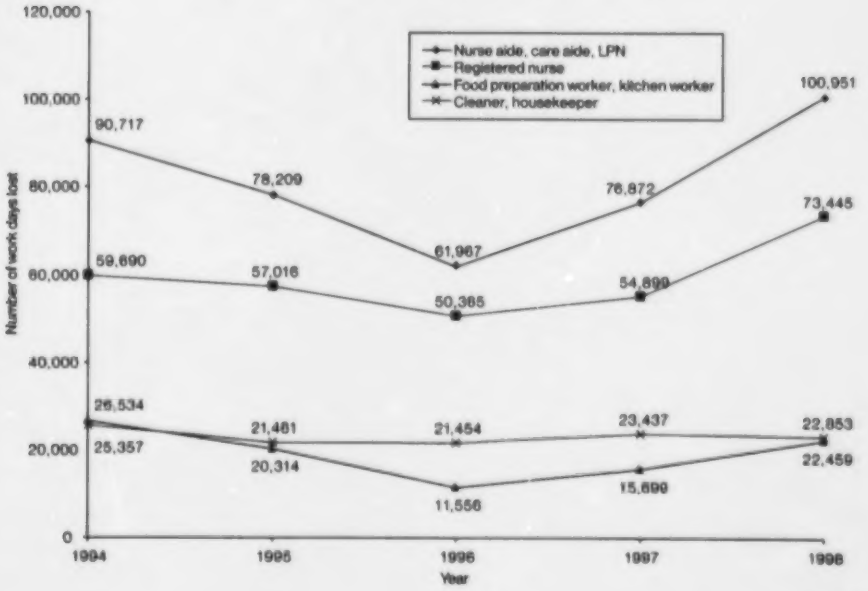
Total claims accepted in hospitals and related industries from 1994 to 1998 = 23,353

For each of the four occupation categories listed on page 20, line graphs show the yearly numbers of time-loss claims and the days lost. Note that these graphs show *counts* rather than *rates* for workers in these occupations. The WCB cannot determine which occupation has the highest or lowest rate of claims or days lost as the WCB does not collect data on person-years by occupation.

Number of claims in hospitals and related industries, by occupation and year, 1994–98



Days lost in hospitals and related industries, by occupation and year, 1994–98



Nurse aides, care aides, and LPNs: Common accident types

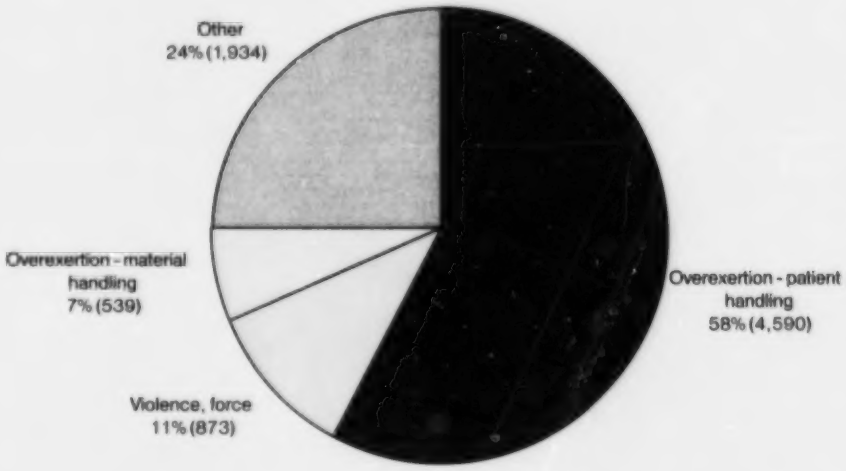
There were 7,936 time-loss claims accepted from nurse aides, care aides, and LPNs in hospitals and related industries from 1994 to 1998. As shown in the pie graph below, most claims were due to the following types of accidents:

- Overexertion–patient handling (58%)
- Violence, force (11%)
- Overexertion–material handling (7%)

Accident types belonging to the "other" category include:

- Fall on same level (6.7%, 529 claims)
- Other body motion (non-repetitive motion) (5.2%, 415 claims)
- All else (12.5%, 992 claims)

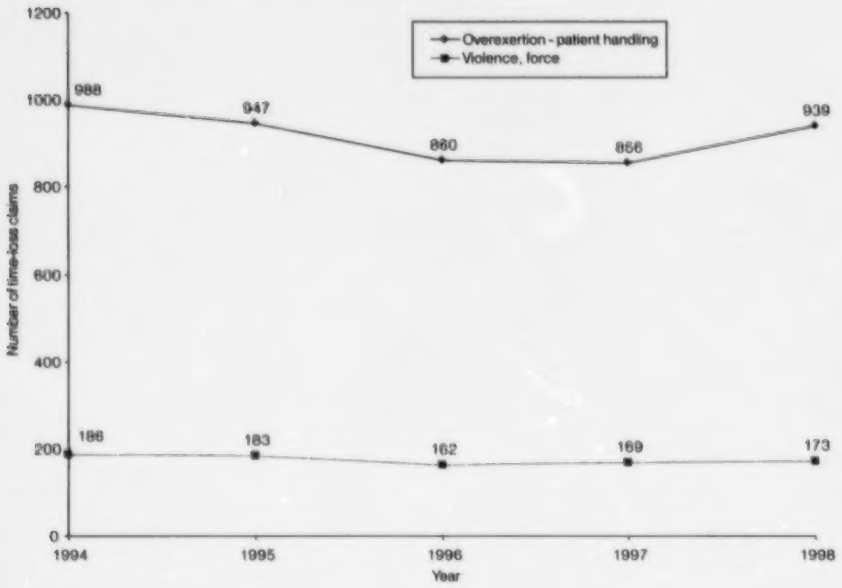
Accident types for nurse aides, care aides, and LPNs, 1994–98



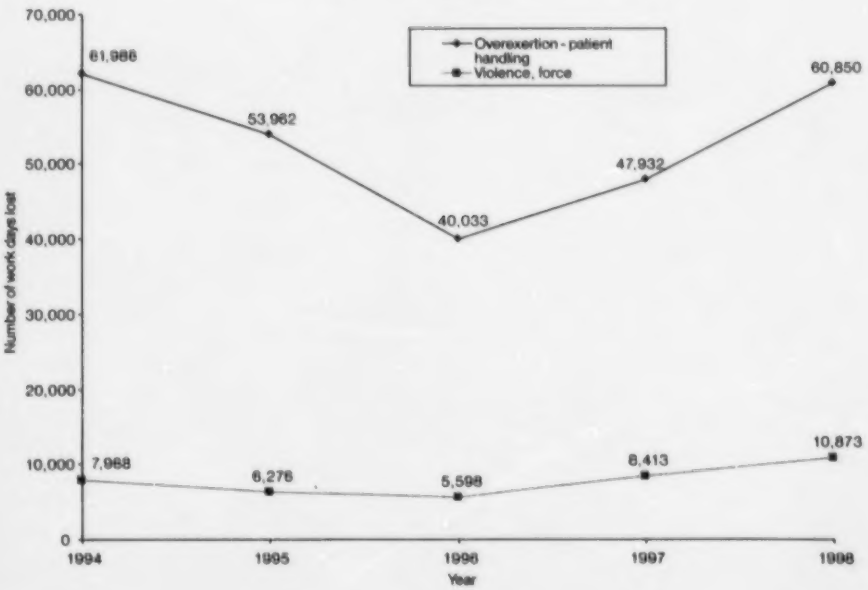
Total claims accepted for nurse aide, care aide, LPN from 1994 to 1998 = 7,936

The following line graphs show the yearly numbers of time-loss claims and the days lost for the top two accident types during this five-year period. These are overexertion—patient handling and violence or force, which together account for 69% of claims.

Claims for nurse aides, care aides, and LPNs, by accident type and year, 1994–98

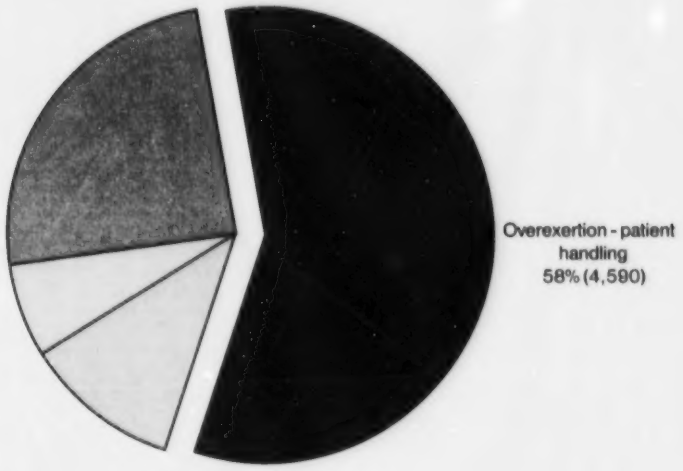


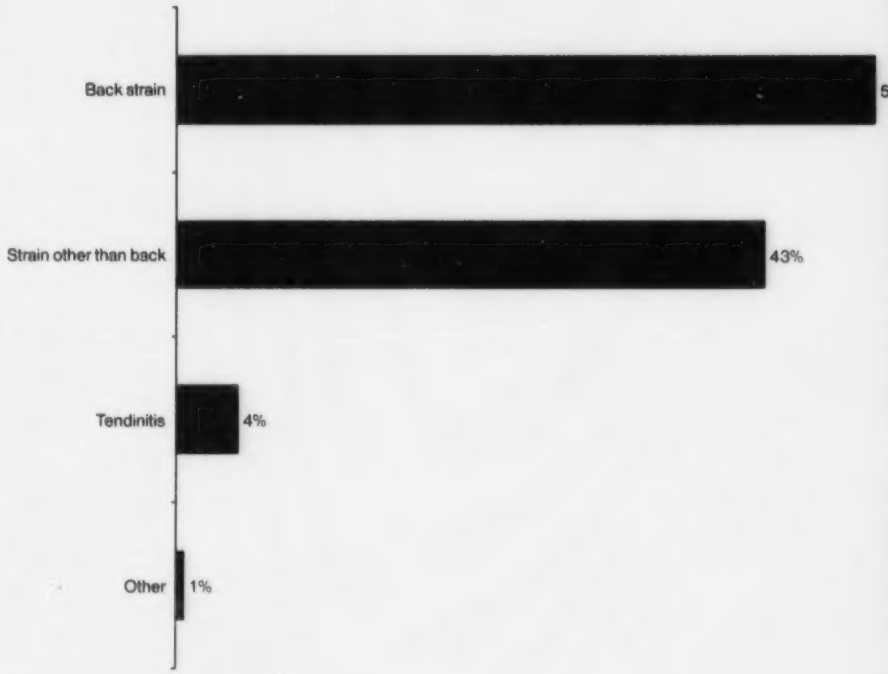
Days lost by nurse aides, care aides, and LPNs, by accident type and year, 1994–98



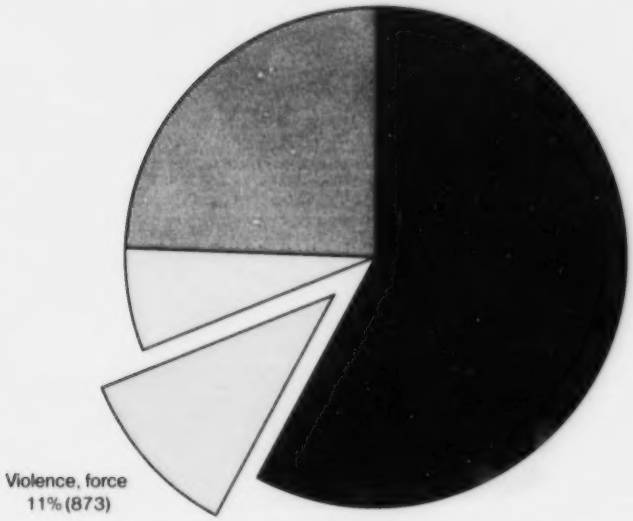
The bar graphs on pages 24–25 show the most common injury types resulting from overexertion—patient handling accidents and from violence or force.

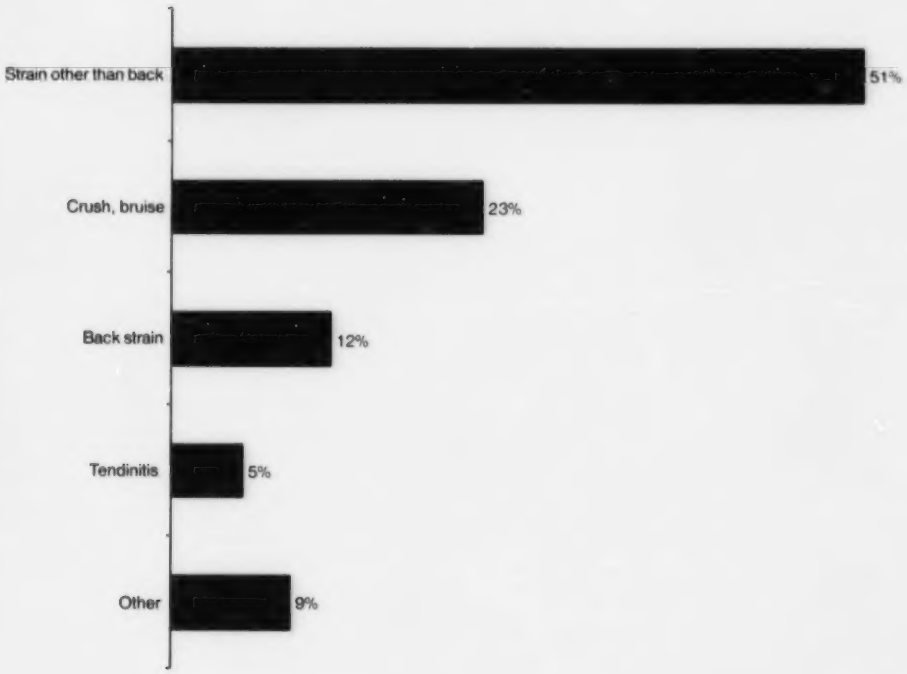
Injuries to nurse aides, care aides, and LPNs caused by overexertion—patient handling accidents, 1994–98





Injuries to nurse aides, care aides, and LPNs caused by violence or force, 1994–98





Registered nurses: Common accident types

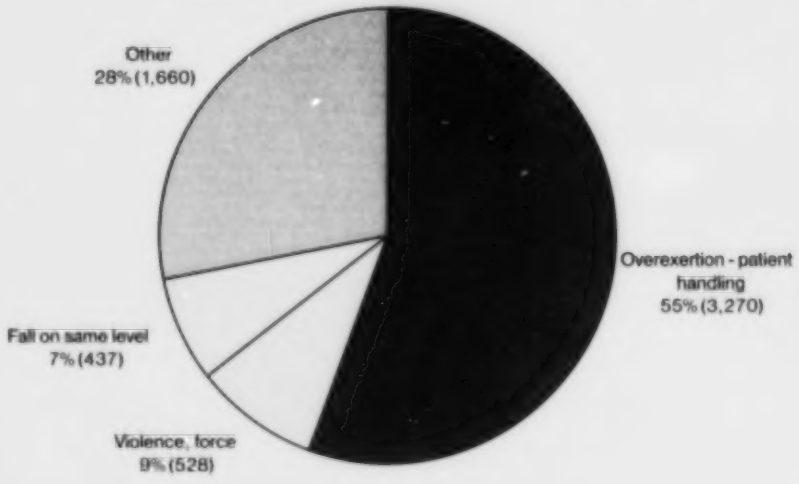
There were 5,895 time-loss claims accepted from registered nurses in hospitals and related industries from 1994 to 1998. As shown in the pie graph below, most claims were due to the following types of accidents:

- Overexertion–patient handling (55%)
- Violence, force (9%)
- Fall on same level (7%)

Accident types belonging to the "other" category include:

- Other body motion (non-repetitive motion) (6.8%, 399 claims)
- Overexertion–material handling, (6.5%, 381 claims)
- Toxic or noxious (5.0%, 296 claims)
- All else (9.9%, 584 claims)

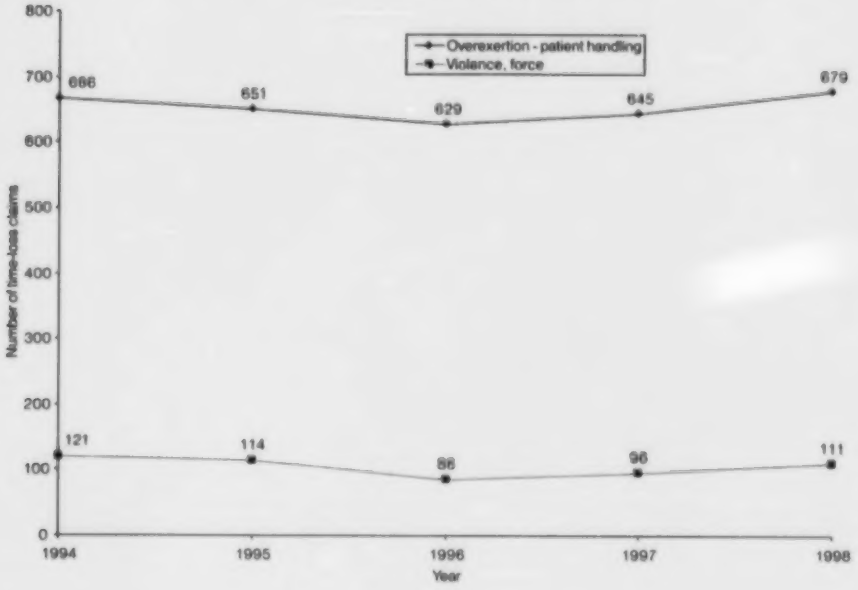
Accident types for registered nurses, 1994–98



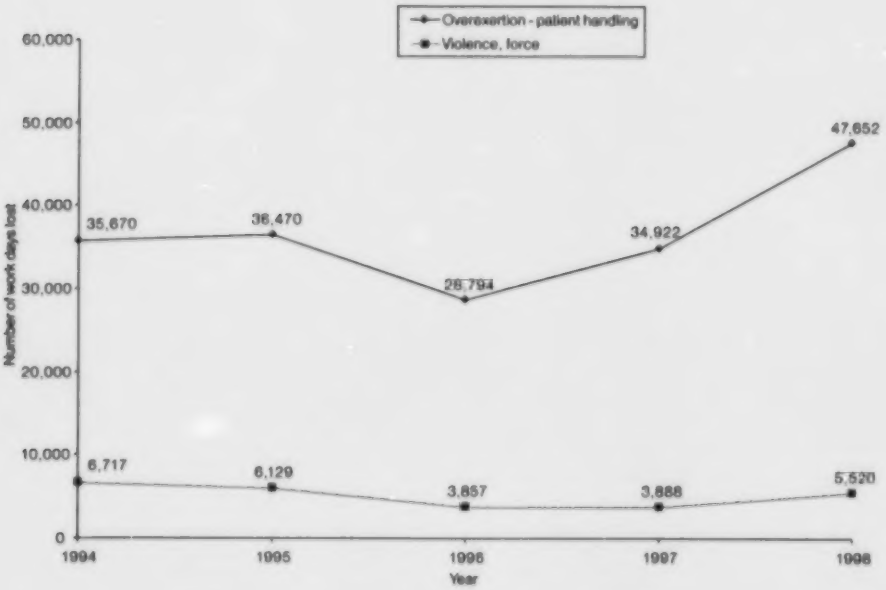
Total claims accepted for registered nurse from 1994 to 1998 = 5,895

The following line graphs show the yearly numbers of time-loss claims and the days lost for the top two accident types during this five-year period. These are overexertion—patient handling and violence or force, which together account for 64% of claims.

Claims for registered nurses, by accident type and year, 1994–98

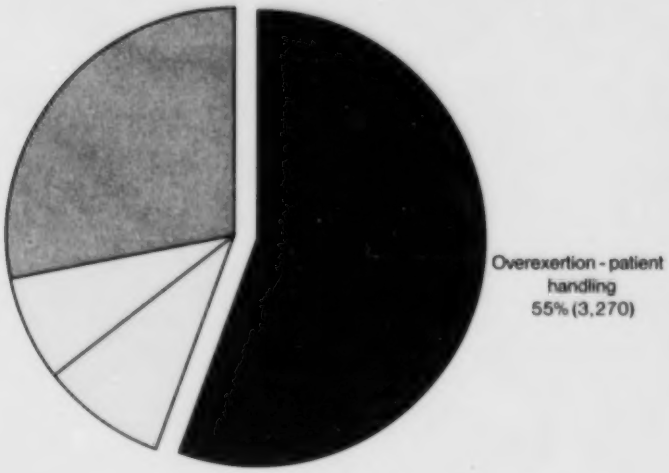


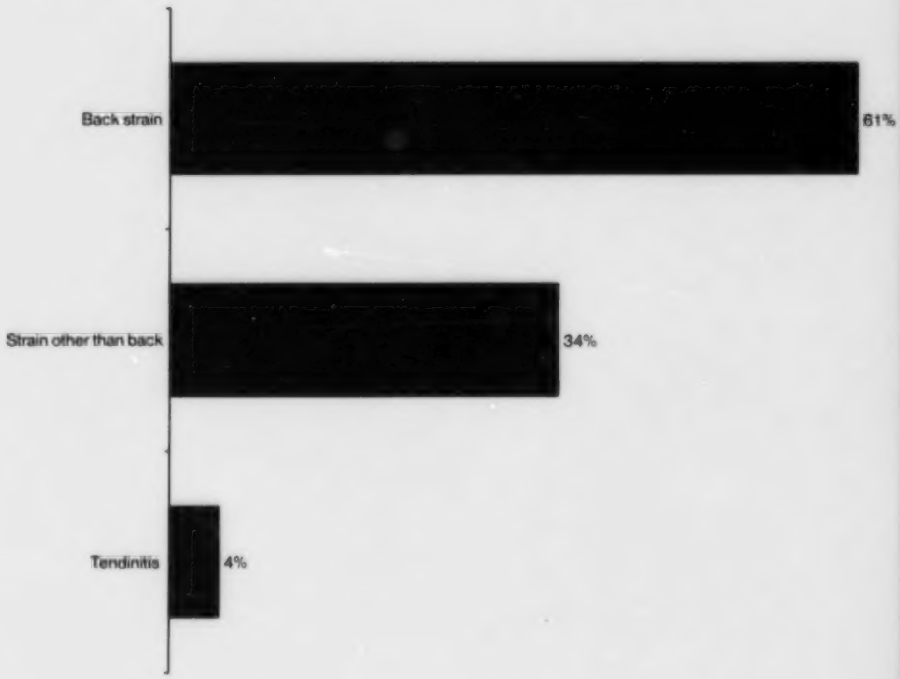
Days lost by registered nurses, by accident type and year, 1994–98



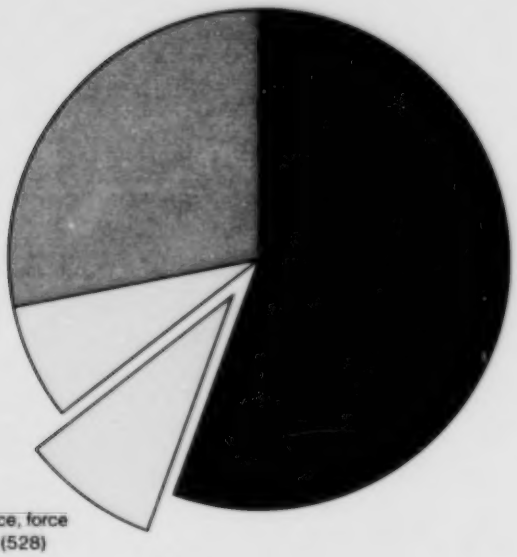
The bar graphs on pages 28–29 show the most common injury types resulting from overexertion—patient handling accidents and from violence or force.

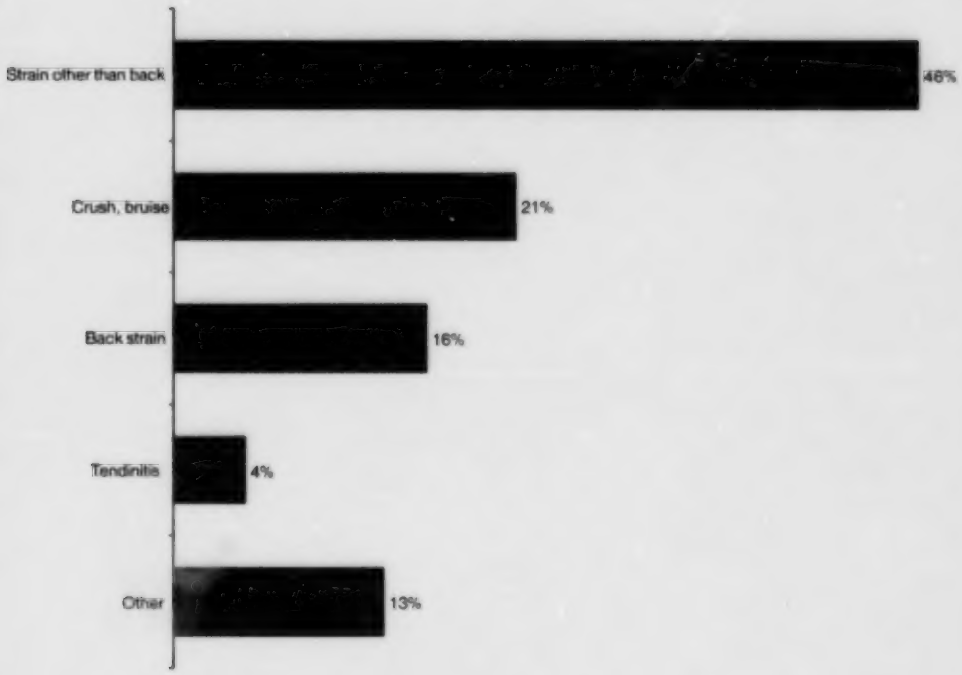
Injuries to registered nurses caused by overexertion—patient handling accidents, 1994–98





Injuries to registered nurses caused by violence or force, 1998–94





Staff and management work together to reduce injuries

When staff in a cardiac surgical intensive care unit (CSICU) complained about musculoskeletal injuries, they did so for good reason. Ten of 27 staff members had suffered injuries in one year. During a six-month period, the unit had seven WCB claims, four of which involved significant time off work. Three individuals have suffered injuries so severe they have been off work for three to five years.

One staff member who hurt her back moving a patient considers herself lucky that the injury was not worse: "Some of the staff have had disc surgery. To see them in such pain, going through rehabilitation and then worrying they may never again do the work they love, is heartbreaking. To find out you are unable to do the work you are trained for is quite devastating."

The current patient care manager was new to the unit when staff came to her with serious concerns about workplace safety. Their work with patients recovering from open-heart surgery involves a lot of physical work—lifting, turning, and repositioning patients, who often outweigh staff by two or three times. "So many staff had hurt themselves I was shocked," says the manager. "They were so frustrated—something had to be done."

A joint committee made up of registered nurses, a physiotherapist, the occupational health nurse, and the patient care manager worked for six months to identify and assess hazards and recommend solutions.

The committee toured other CSICUs, circulated a staff questionnaire, and conducted an ergonomic assessment by videotaping the unit during two 12-hour shifts. The video assessment, which looked specifically at layout of equipment around bedsides, validated complaints from staff about the position of equipment. The patient care manager explains: "We put the tape on fast forward and noticed the frequency of head and neck movement as nurses looked up and down at bedside monitors that were positioned too high on shelving. It's a wonder they don't have more neck problems than they do."

The committee made recommendations regarding equipment design and selection, clinical pathways, and manual lifting techniques. New beds that could be lowered closer to the floor for easier and safer patient transfers were ordered. Ceiling-mounted, height-adjustable IV poles were also purchased. This reduced the amount of overhead reaching associated with the changing of IV bags. Monitors have been lowered to keep the neck in a more neutral posture and reduce neck strain. A video on stretching exercises was also developed to help staff stay limber and keep their muscles ready for lifting. Even though the process of finding solutions is not complete, injuries are already down.

According to the patient case manager, part of the reason injuries are down is that the consultative process has helped heighten awareness. "Everyone is aware of the problem areas and they take adequate precautions. I can't remember the last time I filled out an incident report—it's been at least six to nine months. Awareness may be a key element, but knowledge is just as important and that's why staff deserve credit for reducing injuries. They work on the front lines every day, they know the issues, and their invoivement in the process has helped make their workplace safer."

Food preparation workers and kitchen workers: Common accident types

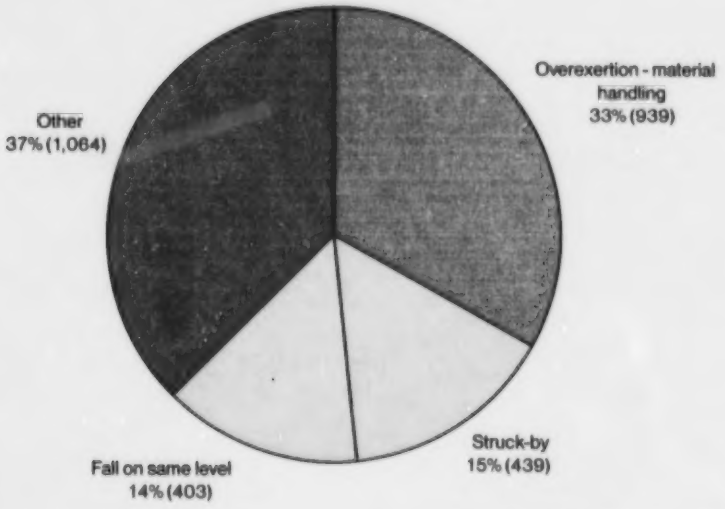
There were 2,845 time-loss claims accepted from food preparation workers and kitchen workers in hospitals and related industries from 1994 to 1998. As shown in the graph below, most claims were due to the following types of accidents:

- Overexertion—material handling (33%)
- Struck-by (15%)
- Fall on same level (14%)

Accident types belonging to the "other" category include:

- Heat, cold (9.1%, 260 claims)
- Other body motion (non-repetitive motion) (8.5%, 243 claims)
- Strike against (6.7%, 191 claims)
- All else (13%, 370 claims)

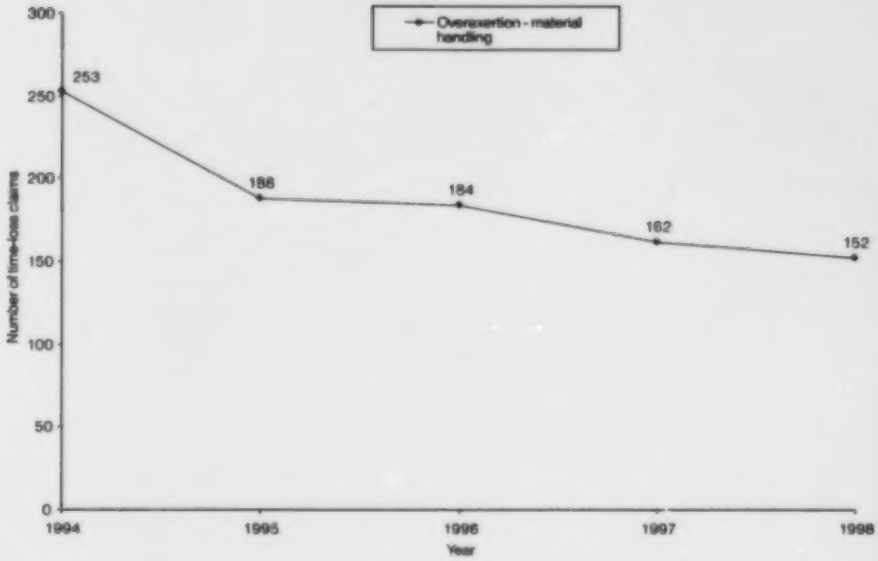
Accident types for food preparation workers and kitchen workers, 1994–98



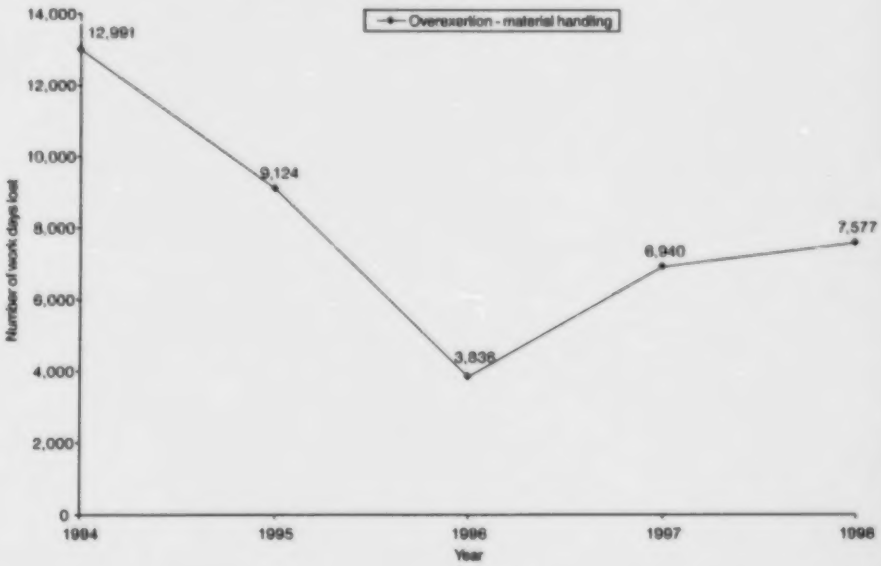
Total claims accepted for food preparation worker, kitchen worker from 1994 to 1998 = 2,845

The following line graphs show the yearly numbers of time-loss claims and the days lost because of overexertion–material handling accidents during this five-year period.

Claims for food preparation workers and kitchen workers, by accident type and year, 1994–98

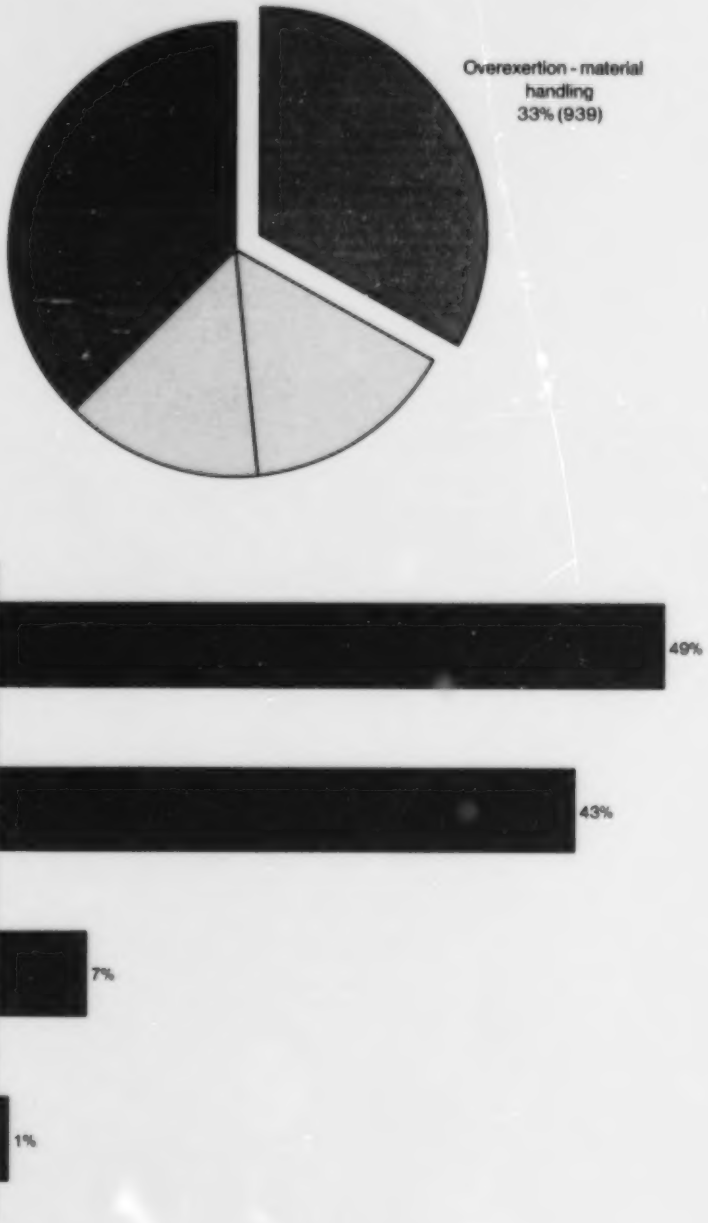


Days lost by food preparation workers and kitchen workers, by accident type and year, 1994–98



The bar graph shows the most common injury types resulting from overexertion–material handling accidents.

Injuries to food preparation workers and kitchen workers caused by overexertion—material handling accidents, 1994–98



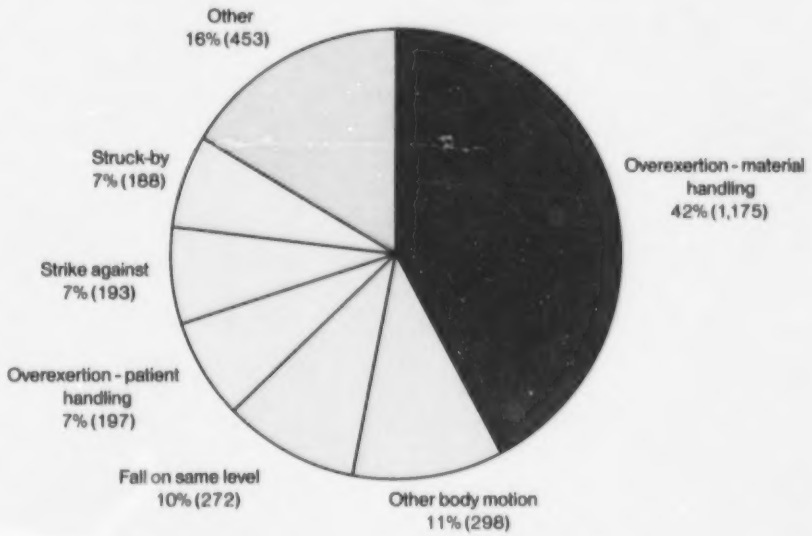
Cleaners and housekeepers: Common accident types

There were 2,776 time-loss claims accepted from cleaners and housekeepers in hospitals and related industries from 1994 to 1998. As shown in the pie graph below, most claims were due to the following types of accidents:

- Overexertion--material handling (42%)
- Other body motion (non-repetitive motion) (11%)
- Fall on same level (10%)
- Overexertion--patient handling (7%)
- Stike against (7%)
- Struck-by (7%)

None of the accident types belonging to the "other" category accounted for more than 3.8% of the claims.

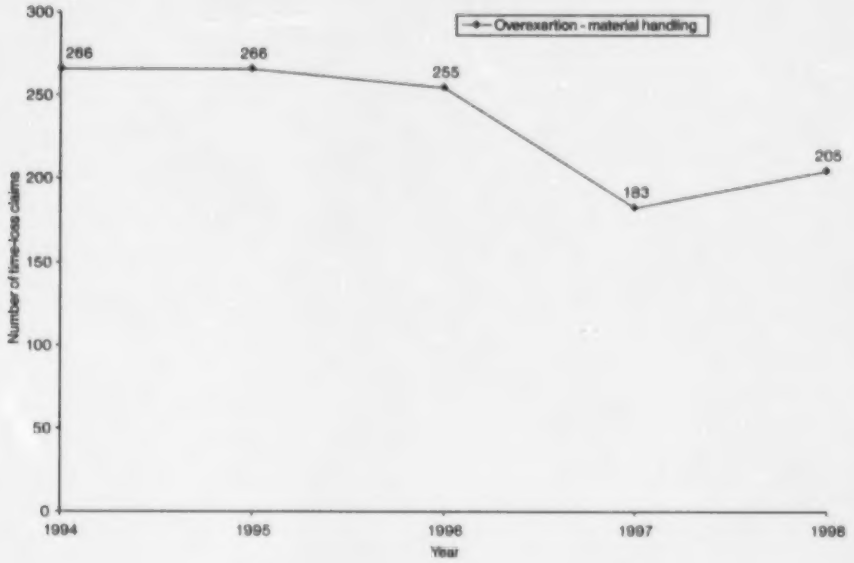
Accident types for cleaners and housekeepers, 1994–98



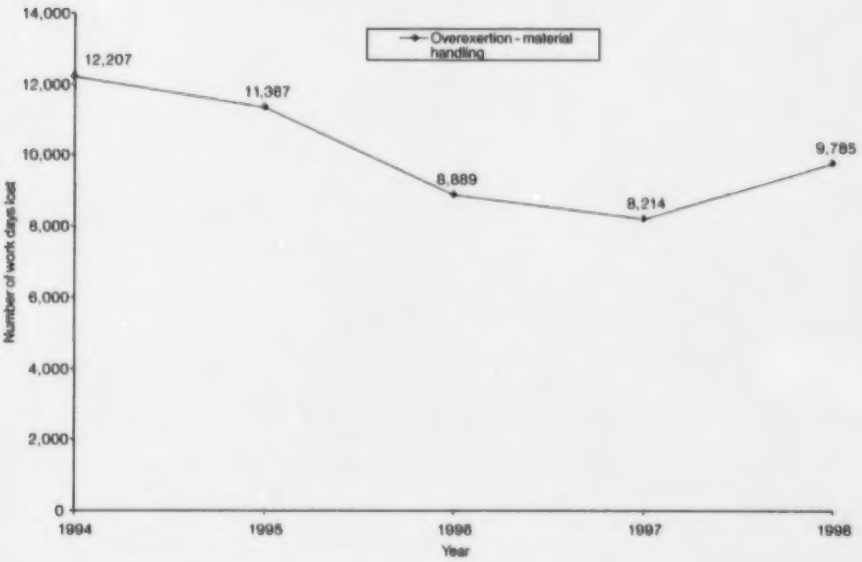
Total claims accepted for cleaner, housekeeper from 1994 to 1998 = 2,776

The following line graphs show the yearly numbers of time-loss claims and the days lost because of overexertion—material handling accidents during this five-year period.

Claims for cleaners and housekeepers, by accident type and year, 1994–98



Days lost by cleaners and housekeepers, by accident type and year, 1994–98



The bar graph shows the most common injury types resulting from overexertion–material handling accidents.

Injuries to cleaners and housekeepers caused by overexertion—material handling accidents, 1994–98

For information about preventing occupational injury and disease, see page 65.

THE NURSING HOME INDUSTRY

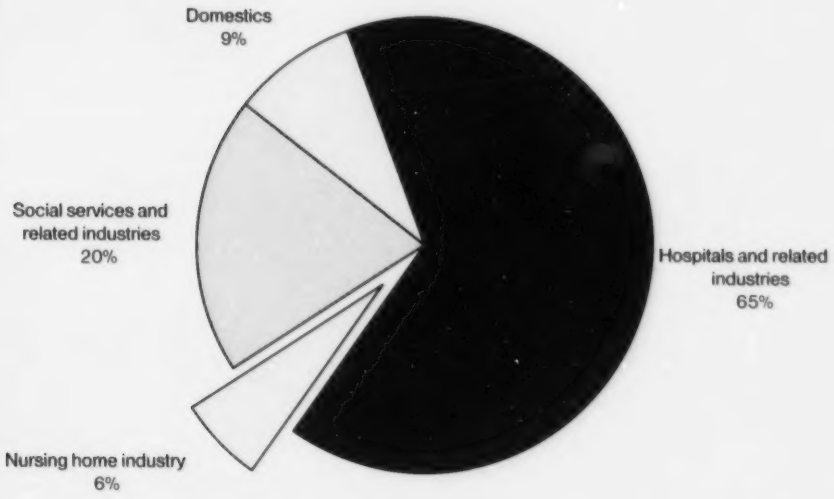
(Subclass Industry 62605)

Overview

Subclass industry 62605 consists entirely of nursing homes. Some nursing homes, however, may be registered in a different category, such as 62608 (social services and related industries). If you are not sure which subclass industry your organization belongs to, check the classification on your WCB payroll remittance form or call the WCB Assessments Department at 604 244-6181 or toll-free in B.C. at 1 888 922-2768 for assistance.

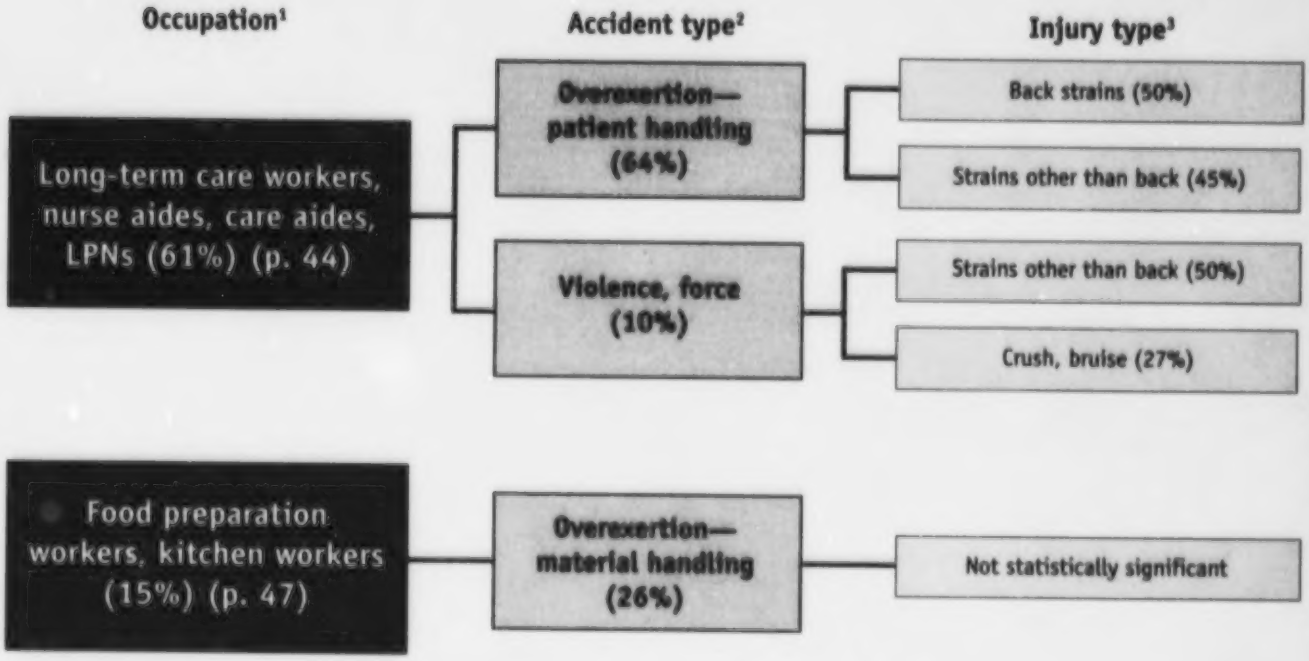
From 1994 to 1998, there were 35,751 time-loss claims from the health care industry as a whole. Of these, 6% involved workers in the nursing home industry, as shown in the following graph.

Percentage of claims by subclass industry, 1994–98



The following chart summarizes the occupations, accident types, and injury types that accounted for most of the time-loss claims from workers in nursing homes from 1994 to 1998.

Summary of claims in the nursing home industry


Occupation[1]
Accident type[2]
Injury type[3]
Long-term care workers, nurse aides, care aides, LPNs (61%) (p. 44)
Overexertion—patient handling (64%)
Back strains (50%)
Strains other than back (45%)
Violence, force (10%)
Strains other than back (50%)
Crush, bruise (27%)
Food preparation workers, kitchen workers (15%) (p. 47)
Overexertion—material handling (26%)
Not statistically significant

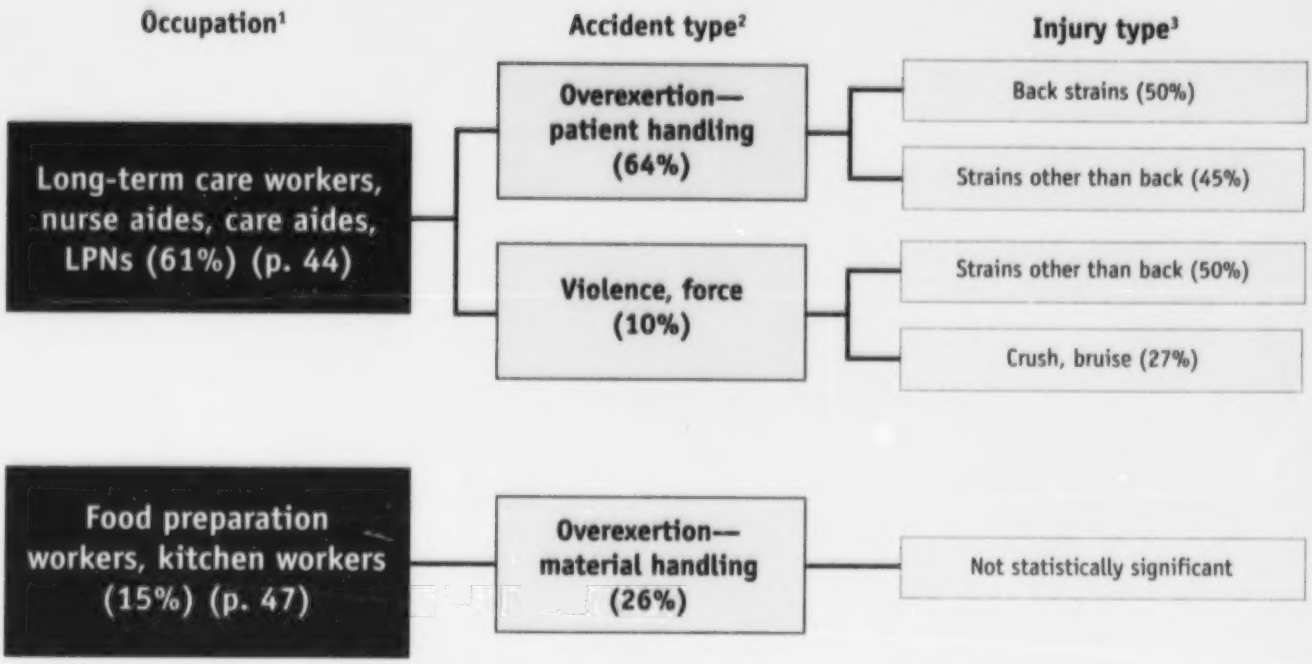
[1] *The percentages shown are the percentages of all time-loss claims attributable to given occupation categories in nursing homes.*

[2] *The percentages shown are the percentages of time-loss claims attributable to the top one or two accident types for given occupation categories.*

[3] *The percentages shown are the percentages of time-loss claims attributable to the top two injury types for given accident types.*

The following chart summarizes the occupations, accident types, and injury types that accounted for most of the time-loss claims from workers in nursing homes from 1994 to 1998.

Summary of claims in the nursing home industry


Occupation[1]
Accident type[2]
Injury type[3]
Long-term care workers, nurse aides, care aides, LPNs (61%) (p. 44)
Overexertion—patient handling (64%)
Back strains (50%)
Strains other than back (45%)
Violence, force (10%)
Strains other than back (50%)
Crush, bruise (27%)
Food preparation workers, kitchen workers (15%) (p. 47)
Overexertion—material handling (26%)
Not statistically significant

[1] *The percentages shown are the percentages of all time-loss claims attributable to given occupation categories in nursing homes.*

[2] *The percentages shown are the percentages of time-loss claims attributable to the top one or two accident types for given occupation categories.*

[3] *The percentages shown are the percentages of time-loss claims attributable to the top two injury types for given accident types.*

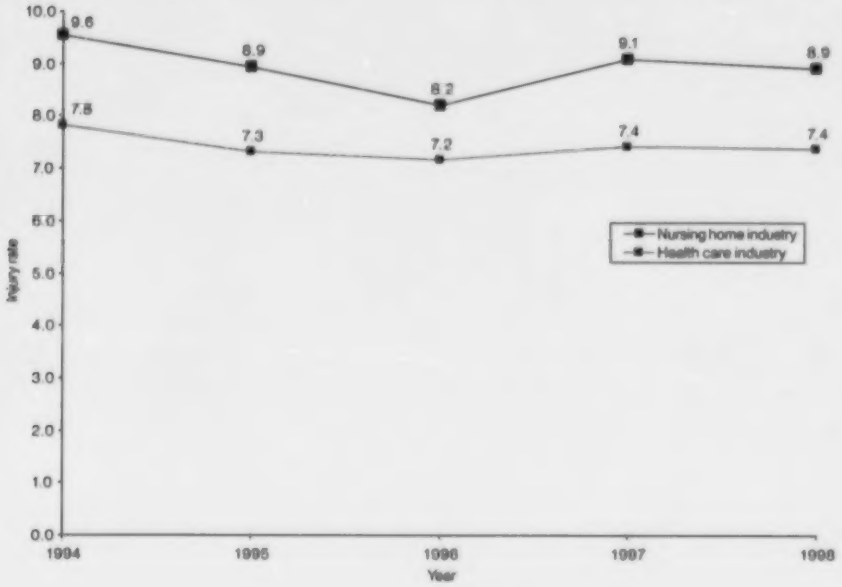
Injury rate

The graph below shows the annual injury rate based on time-loss claims accepted by the WCB for all workers in the nursing home industry for the 1994–98 period. It also shows the corresponding injury rate for workers in the health care industry as a whole.

From 1994 to 1998, a total of 2,139 claims were accepted from workers in the nursing home industry, resulting in an average injury rate of 8.9. From 1994 to 1998, time-loss claims resulted in 90,284 days lost and $8,299,280 in claims costs.

In 1998, the injury rate for workers in this subclass industry was 8.9. This was 20% higher than the injury rate for workers in the health care industry as a whole (7.4), and 85% higher than the rate for all workers in British Columbia (4.8).

Injury rates: Nursing home industry compared with the health care industry as a whole, 1994–98

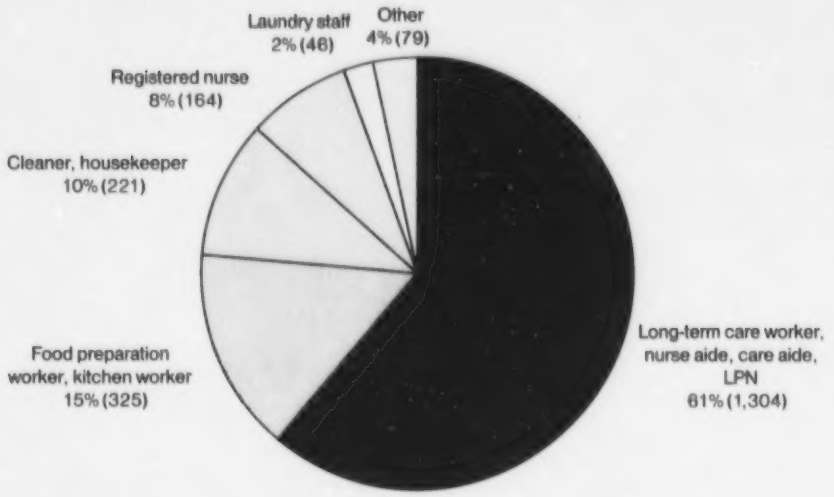


Claims by occupation

The pie graph below shows which occupations in the nursing home industry accounted for the 2,139 time-loss claims accepted from 1994 to 1998. The occupation categories with the most claims were:

- Long-term care worker, nurse aide, care aide, LPN (61%)
- Food preparation worker, kitchen worker (15%)
- Cleaner, housekeeper (10%)
- Registered nurse (8%)
- Laundry staff (2%)

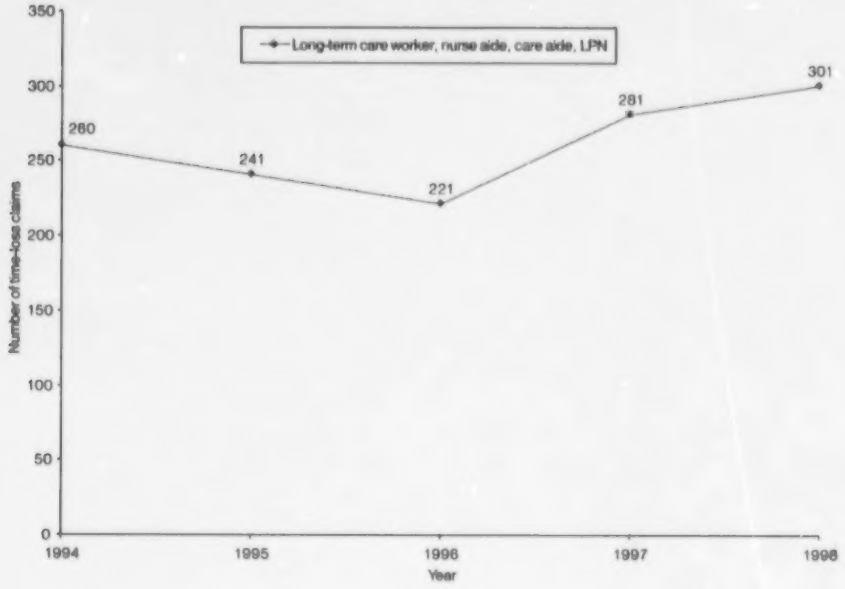
Percentage of claims in the nursing home industry, by occupation, 1994–98



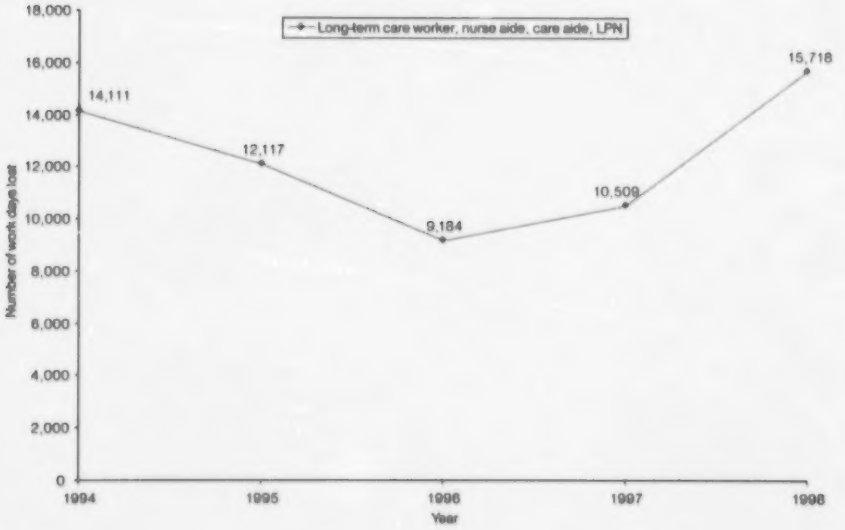
Total claims accepted in nursing home industry from 1994 to 1998 = 2,139

The following line graphs show the yearly numbers of time-loss claims and the days lost for long-term care workers, nurse aides, care aides, and LPNs. This was the only occupation category for which a statistically significant number of time-loss claims (more than 500) was accepted.

Number of claims in the nursing home industry, by occupation and year, 1994–98



Days lost in the nursing home industry, by occupation and year, 1994–98



Long-term care workers, nurse aides, care aides, and LPNs: Common accident types

There were 1,304 time-loss claims accepted from long-term care workers, nurse aides, care aides, and LPNs in the nursing home industry from 1994 to 1998. As shown in the pie graph below, most claims were due to the following types of accidents:

- Overexertion–patient handling (64%)
- Violence, force (10%)
- Fall on same level (6%)

Accident types belonging to the "other" category include:

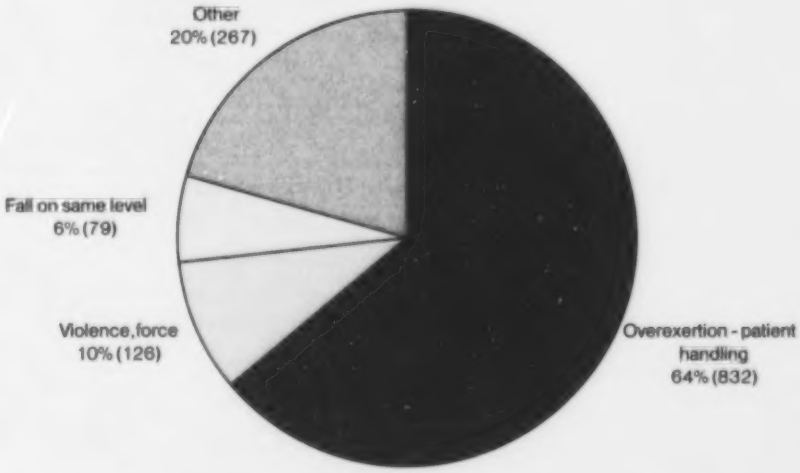
- Other body motion (non-repetitive motion) (5.7%, 74 claims)
- All else (14.8%, 193 claims)

The most common type of accident was overexertion–patient handling (64% of claims from workers in this occupation). The line graphs on page 45 show the yearly numbers of time-loss claims and the days lost because of overexertion–patient handling accidents during this five-year period.

The second most common type of accident involved violence or force (10% of claims). The most common injury types resulting from these accidents were:

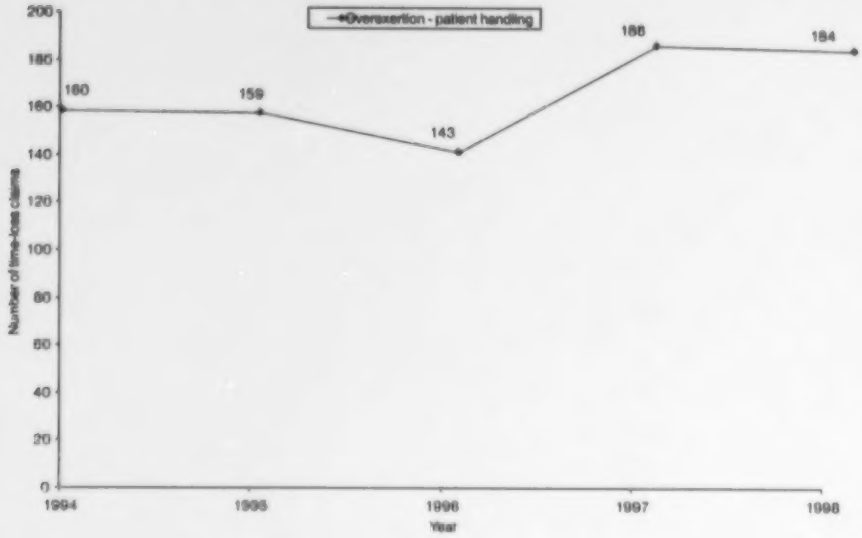
- Strain other than back (50%)
- Crush, bruise (27%)
- Back strain (10%)

Accident types for long-term care workers, nurse aides, care aides, and LPNs, 1994–98

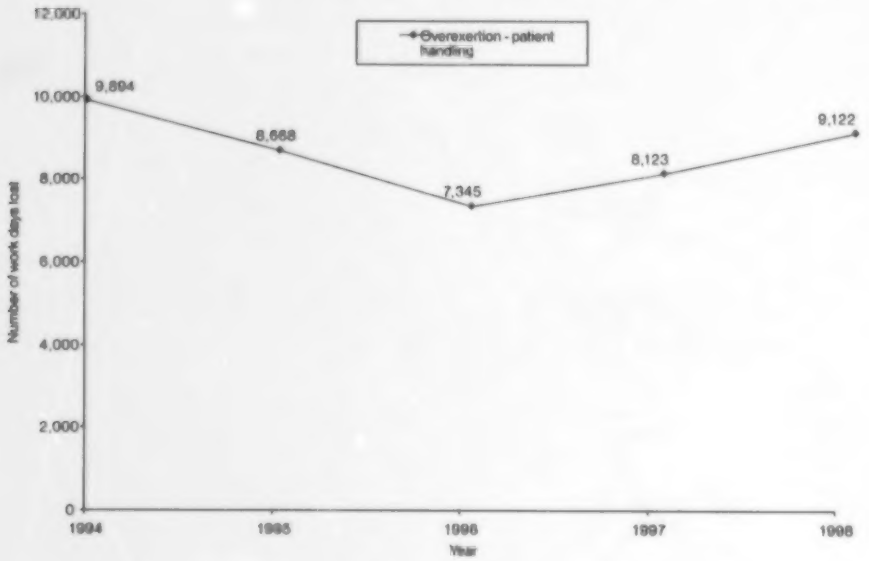


Total claims accepted for long-term care worker, nurse aide, care aide, LPN from 1994 to 1998 = 1,304

Claims for long-term care workers, nurse aides, care aides, and LPNs, by accident type and year, 1994–98

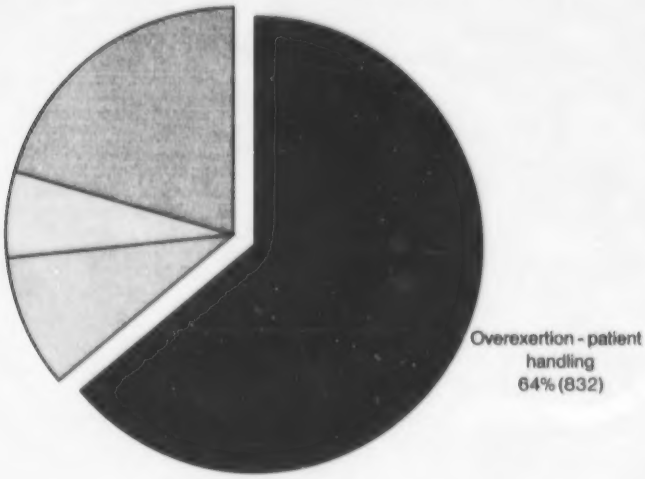


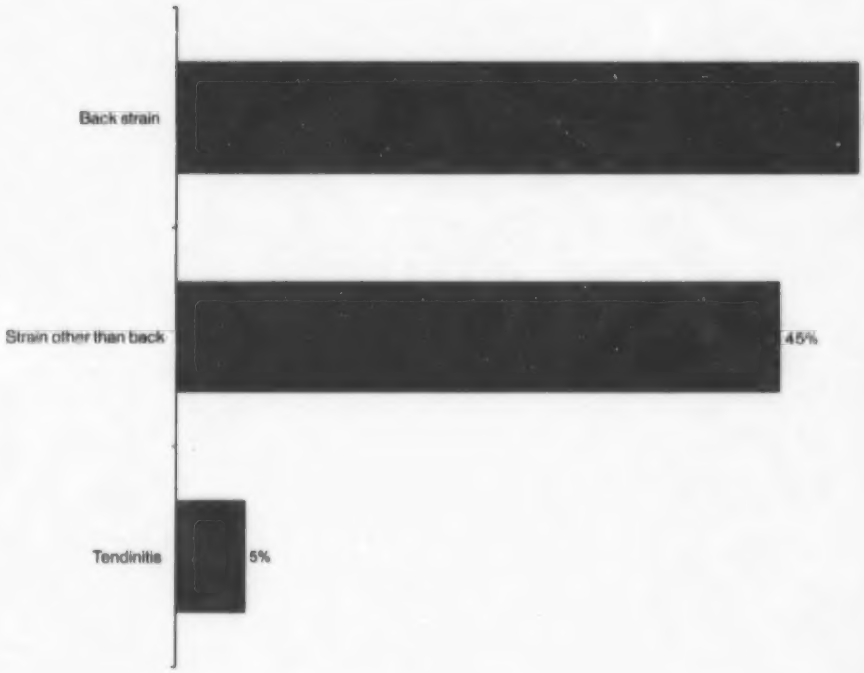
Days lost by long-term care workers, nurse aides, care aides, and LPNs, by accident type and year, 1994–98



The bar graph shows the most common injury types resulting from overexertion—patient handling accidents.

Injuries to long-term care workers, nurse aides, care aides, and LPNs caused by overexertion—patient handling accidents, 1994–98





Food preparation workers and kitchen workers: Common accident types

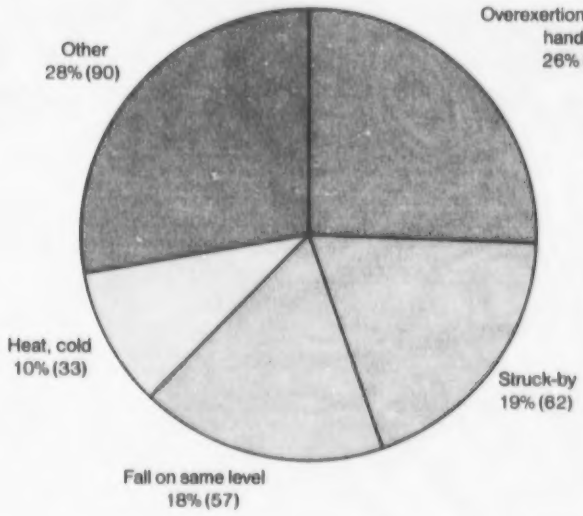
There were 325 time-loss claims accepted from food preparation workers and kitchen workers in the nursing home industry from 1994 to 1998. As shown in the pie graph below, most claims were due to the following types of accidents:

- Overexertion–material handling (26%)
- Struck-by (19%)
- Fall on same level (18%)
- Heat, cold (10%)

Accident types belonging to the "other" category include:

- Other body motion (non-repetitive motion) (8.6%, 28 claims)
- Strike against (6.5%, 21 claims)
- All else (12.6%, 41 claims)

Accident types for food preparation workers and kitchen workers, 1994–98



Total claims accepted for food preparation worker, kitchen worker from 1994 to 1998 = 325

The worker's extended reach is a risk factor for musculoskeletal injuries (MSI).

Low morale contributed to accidents

Providing music to work by may seem like an unlikely way to reduce workplace accidents, but it worked like a charm for one nursing home. The music, along with an adjustment of work hours, helped boost low morale and transform a department with many accidents into one with a sterling safety record.

An occupational health nurse worked with the home's nutritional services staff to reduce the high number of kitchen accidents—most of which resulted in strain injuries. They began by distributing a questionnaire and identifying problem areas. "The initial reaction was just to teach better body mechanics," the nurse says. "We thought that if everyone is having injuries we should look at how they are working. What we found was quite different. We found that staff didn't have enough time to get the job done, so they were always rushed. Morale was also very low."

Staff requested simple changes—gloves that fit, a radio to listen to during their shift, and extra time to complete tasks. Another key change was the hiring of a nutritional services co-ordinator committed to staff involvement. "Staff felt that they weren't being listened to," she says. "The key is getting staff involved in decision making. Before I do anything, I ask them rather than tell them. We brought in a radio and longer gloves and they felt they were being listened to. We also had a few potluck dinners and that boosted employee morale."

Staff also commented on hours of work, staffing levels, and the lack of in-service safety training. "On the surface some of the complaints seemed to have no bearing on the problem—like complaints about specific days and hours of work," says the co-ordinator. "But what we found was that people who worked five days straight were getting tired and injured by the fifth day."

The co-ordinator worked with staff to develop a schedule they could live with, and secured an extra 30 minutes for each shift. She also adjusted an awkward shift so staff with children were able take their kids to and from school.

The occupational health nurse says it is remarkable how a few simple changes have made such a difference. "Now staff are starting to do their own problem solving and if they think something they are doing is too risky, they stop." The results are dramatic. The number of time-loss incidents in the nursing home kitchen has dropped from seven in one year to only one since January 1998.

For information about preventing occupational injury and disease, see page 65.

SOCIAL SERVICES AND

RELATED INDUSTRIES

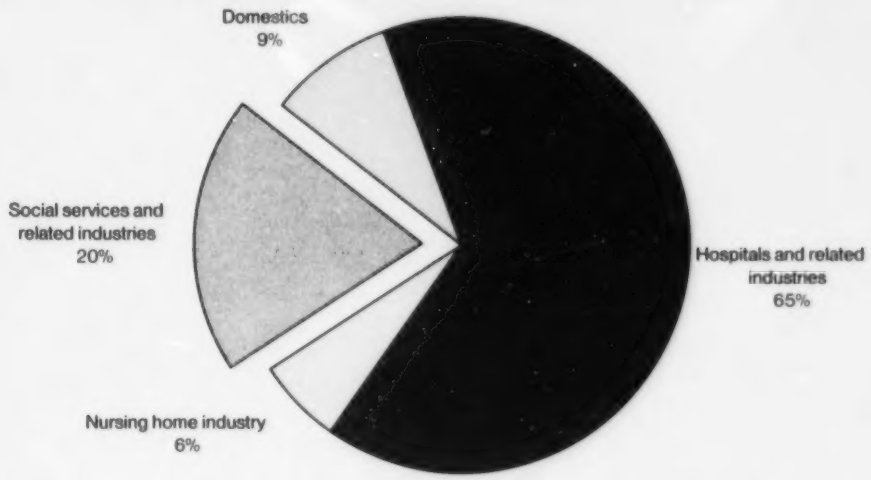
(Subclass Industry 62608)

Overview

Subclass industry 62608 includes a variety of facilities that provide overnight accommodation and physical assistance. Some nursing homes are registered in subclass industry 62608. If you are not sure which subclass industry your organization belongs to, check the classification on your WCB payroll remittance form or call the WCB Assessments Department at 604 244-6181 or toll-free in B.C. at 1 888 922-2768 for assistance.

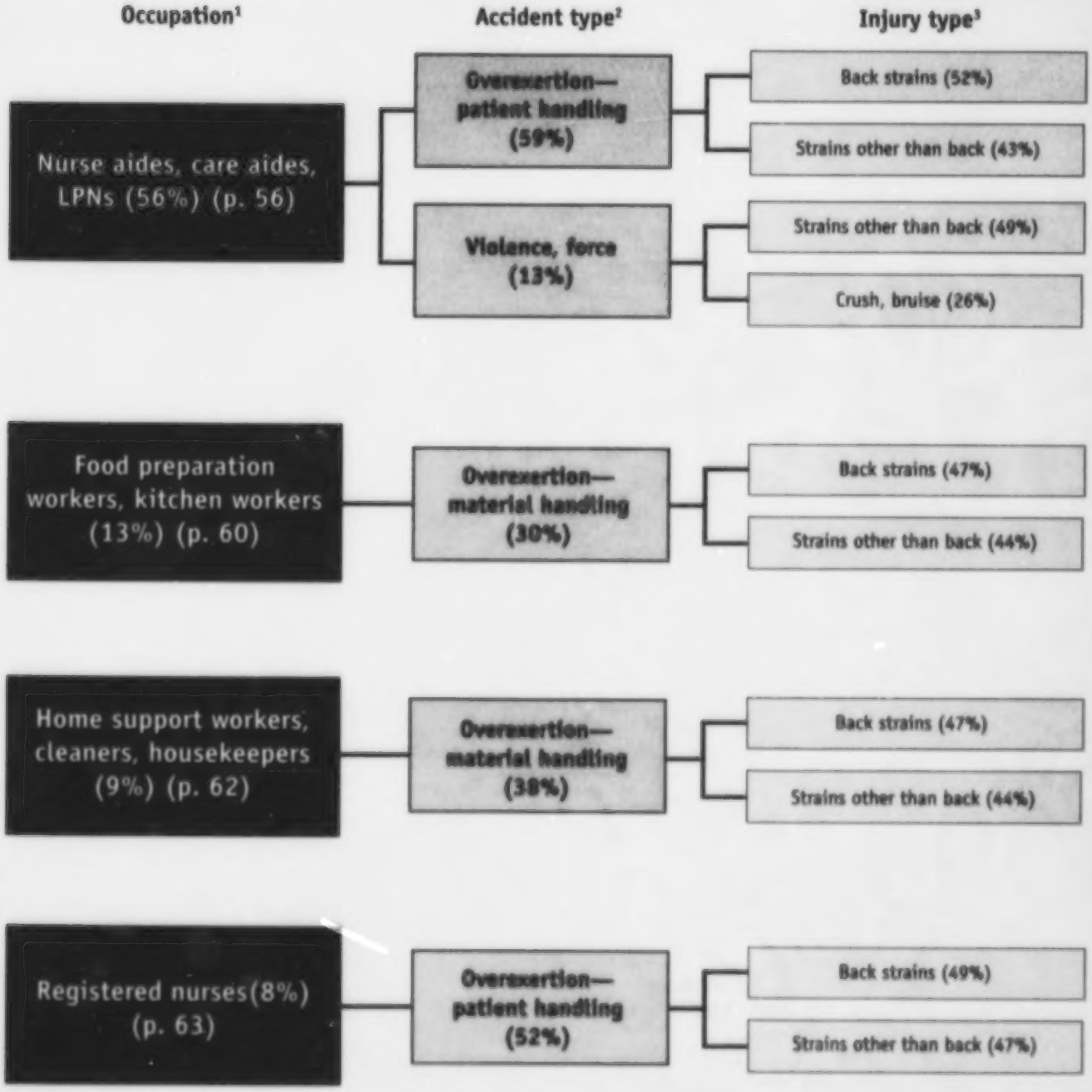
From 1994 to 1998, there were 35,751 time-loss claims from the health care industry as a whole. Of these, 20% involved workers in social services and related industries, as shown in the following graph.

Percentage of claims by subclass industry, 1994–98



The following chart summarizes the occupations, accident types, and injury types that accounted for most of the time-loss claims by workers in social services and related industries from 1994 to 1998.

Summary of claims in social services and related industries


Occupation[1]
Accident type[2]
Injury type[3]
Nurse aides, care aides, LPNs (56%) (p. 56)
Overexertion—patient handling (59%)
Back strains (52%)
Strains other than back (43%)
Violence, force (13%)
Strains other than back (49%)
Crush, bruise (26%)
Food preparation workers, kitchen workers (13%) (p. 60)
Overexertion—material handling (30%)
Back strains (47%)
Strains other than back (44%)
Home support workers, cleaners, housekeepers (9%) (p. 62)
Overexertion—material handling (38%)
Back strains (47%)
Strains other than back (44%)
Registered nurses(8%) (p. 63)
Overexertion—patient handling (52%)
Back strains (49%)
Strains other than back (47%)

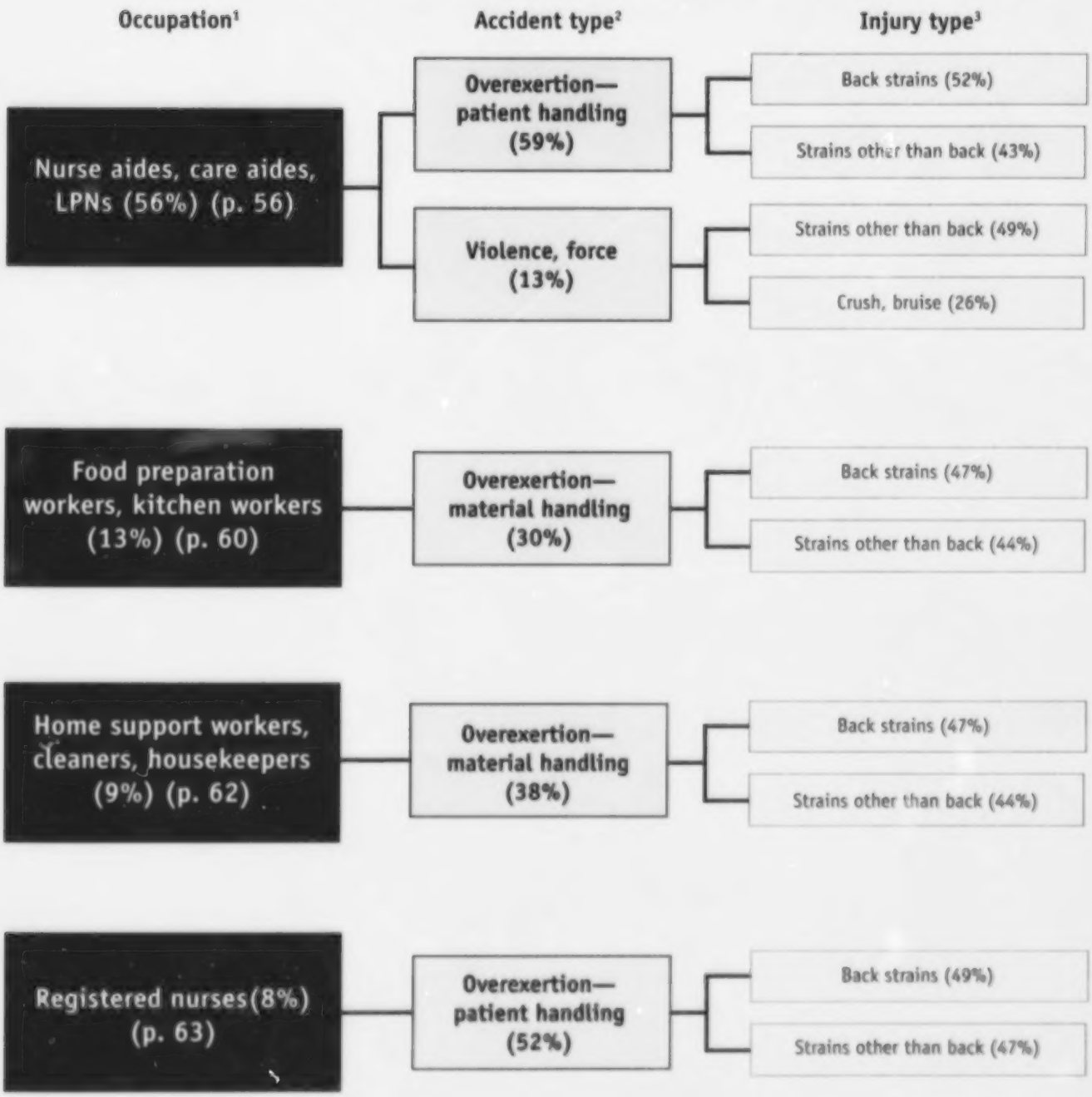
[1] *The percentages shown are the percentages of all time-loss claims attributable to given occupation categories in social services and related industries.*

[2] *The percentages shown are the percentages of time-loss claims attributable to the top one or two accident types for given occupation categories.*

[3] *The percentages shown are the percentages of time-loss claims attributable to the top two injury types for given accident types.*

The following chart summarizes the occupations, accident types, and injury types that accounted for most of the time-loss claims by workers in social services and related industries from 1994 to 1998.

Summary of claims in social services and related industries


Occupation[1]
Accident type[2]
Injury type[3]
Nurse aides, care aides, LPNs (56%) (p. 56)
Overexertion—patient handling (59%)
Back strains (52%)
Strains other than back (43%)
Violence, force (13%)
Strains other than back (49%)
Crush, bruise (26%)
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[1] *The percentages shown are the percentages of all time-loss claims attributable to given occupation categories in social services and related industries.*

[2] *The percentages shown are the percentages of time-loss claims attributable to the top one or two accident types for given occupation categories.*

[3] *The percentages shown are the percentages of time-loss claims attributable to the top two injury types for given accident types.*

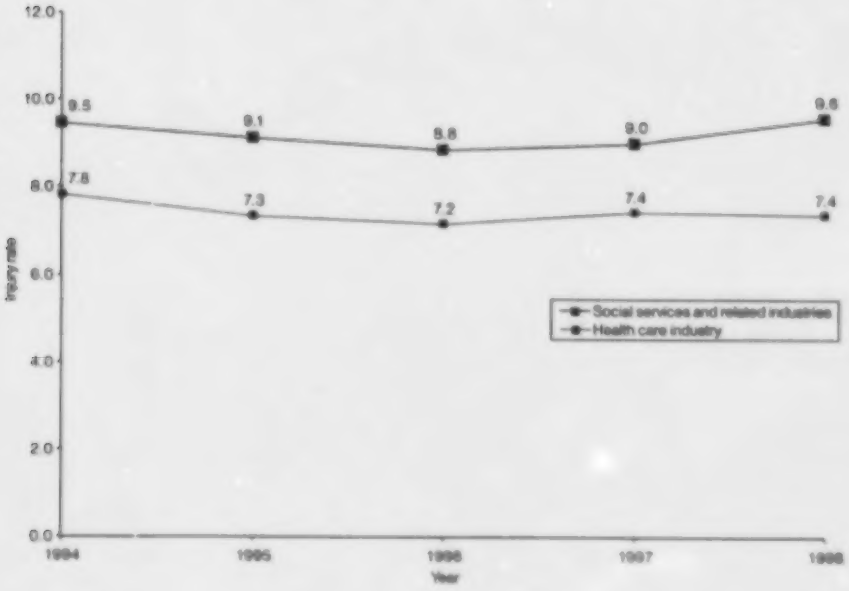
Injury rate

The graph below shows the annual injury rate based on time-loss claims accepted by the WCB for all workers in social services and related industries for the 1994–98 period. It also shows the corresponding injury rate for workers in the health care industry as a whole.

From 1994 to 1998, a total of 7,107 claims were accepted from workers in social services and related industries, resulting in an average injury rate of 9.2. From 1994 to 1998, time-loss claims resulted in 282,245 days lost and $24,896,660 in claims costs.

In 1998, the injury rate for workers in this subclass industry was 9.6. This was 30% higher than the injury rate for workers in the health care industry as a whole (7.4), and 100% higher than the rate for all workers in British Columbia (4.8).

Injury rates: Social services and related industries compared with the health care industry as a whole, 1994–98



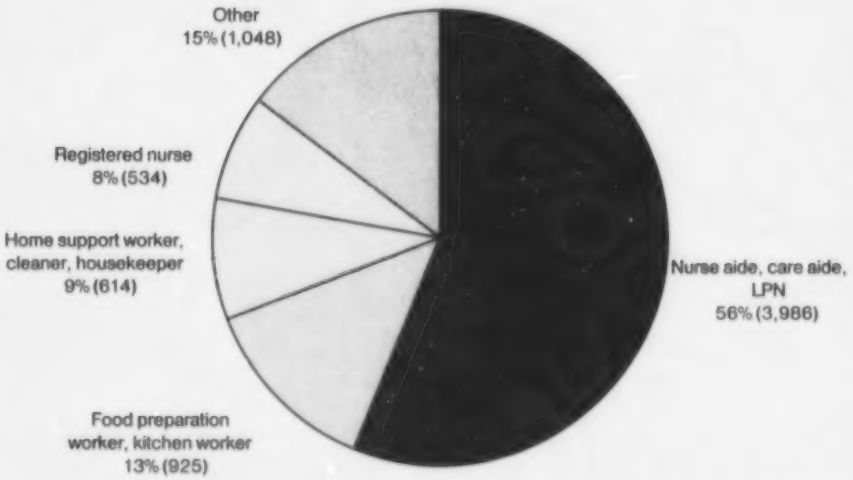
Claims by occupation

The pie graph below shows which occupations in social services and related industries accounted for the 7,107 time-loss claims accepted from 1994 to 1998. Four occupation categories accounted for 86% of all these claims:

- Nurse aide, care aide, LPN (56%)
- Food preparation worker, kitchen worker (13%)
- Home support worker, cleaner, housekeeper (9%)
- Registered nurse (8%)

None of the occupations belonging to the "other" category accounted for more than 2% of the time-loss claims.

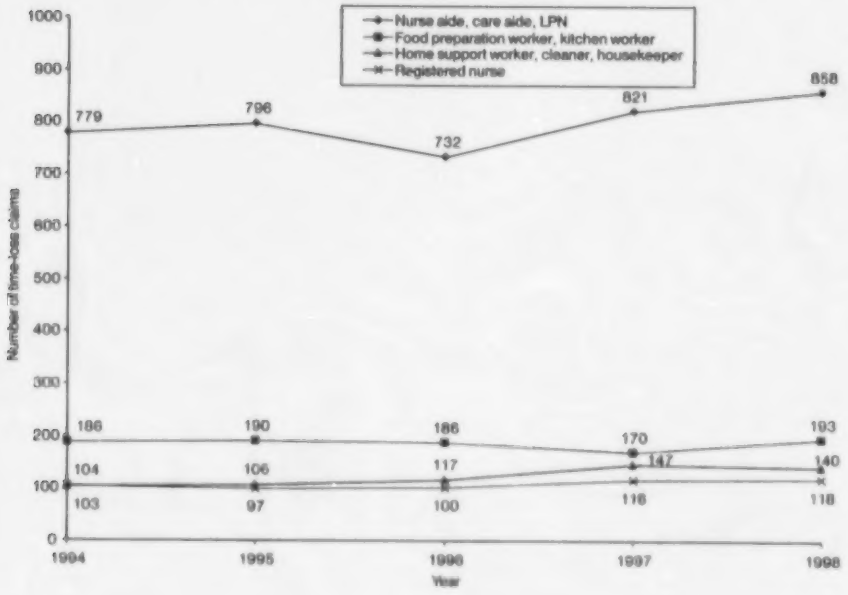
Percentage of claims in social services and related industries, by occupation, 1994–98



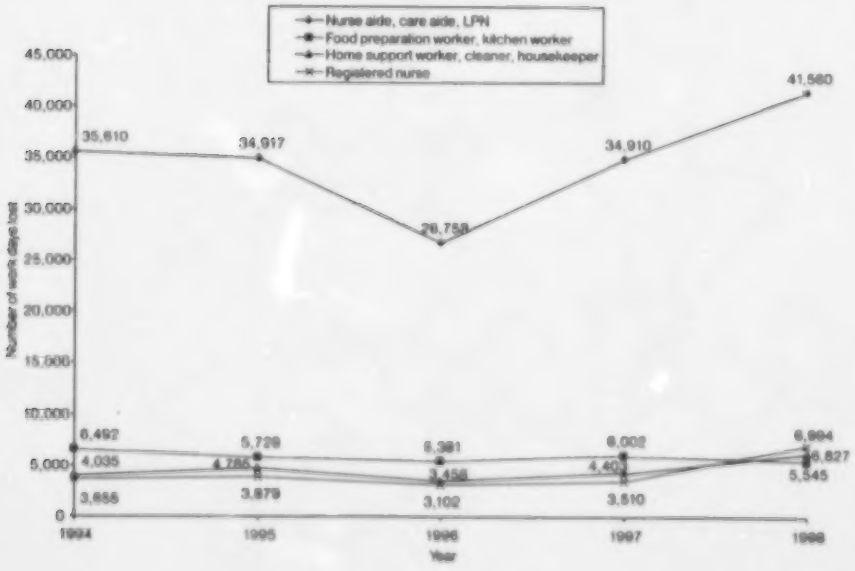
Total claims accepted in social services and related industries from 1994 to 1998 = 7,107

For each of the four occupation categories listed on page 54, line graphs show the yearly numbers of time-loss claims and the days lost. Note that these graphs show *counts* rather than *rates* for workers in these occupations. The WCB cannot determine which occupation has the highest or lowest rate of claims or days lost as the WCB does not collect data on person-years by occupation.

Number of claims in social services and related industries, by occupation and year, 1994–98



Days lost in social services and related industries, by occupation and year, 1994–98



Nurse aides, care aides, and LPNs: Common accident types

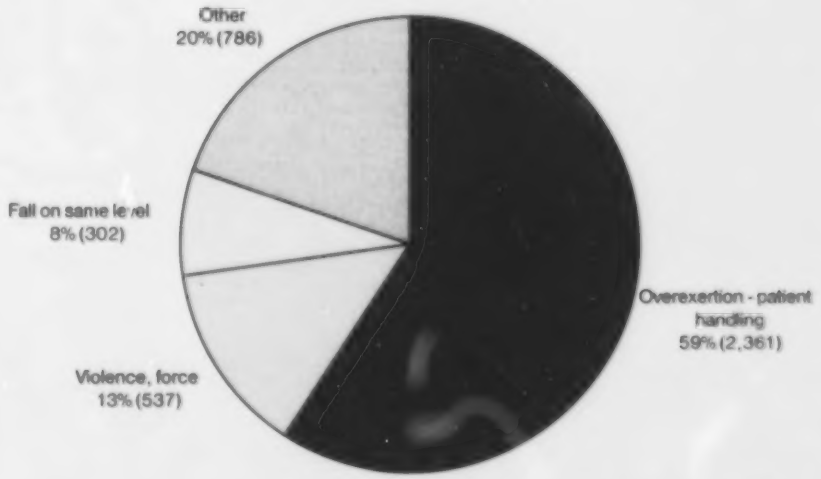
There were 3,986 time-loss claims accepted from nurse aides, care aides, and LPNs in social services and related industries from 1994 to 1998. As shown in the pie graph below, most claims were due to the following types of accidents:

- Overexertion–patient handling (59%)
- Violence, force (13%)
- Fall on same level (8%)

Accident types belonging to the "other" category include:

- Other body motion (non-repetitive motion) (5.1%, 205 claims)
- Overexertion–material handling (5.1%, 202 claims)
- All else (9.5%, 379 claims)

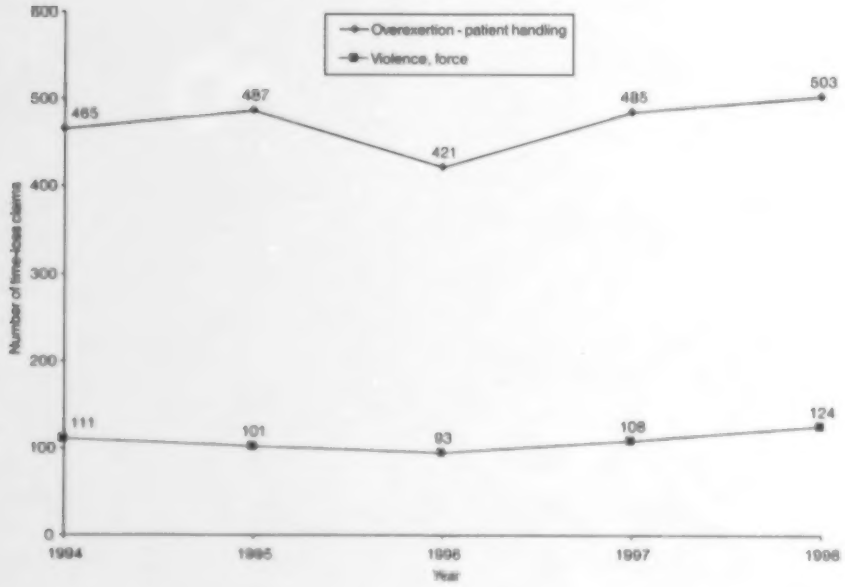
Accident types for nurse aides, care aides, and LPNs, 1994–98



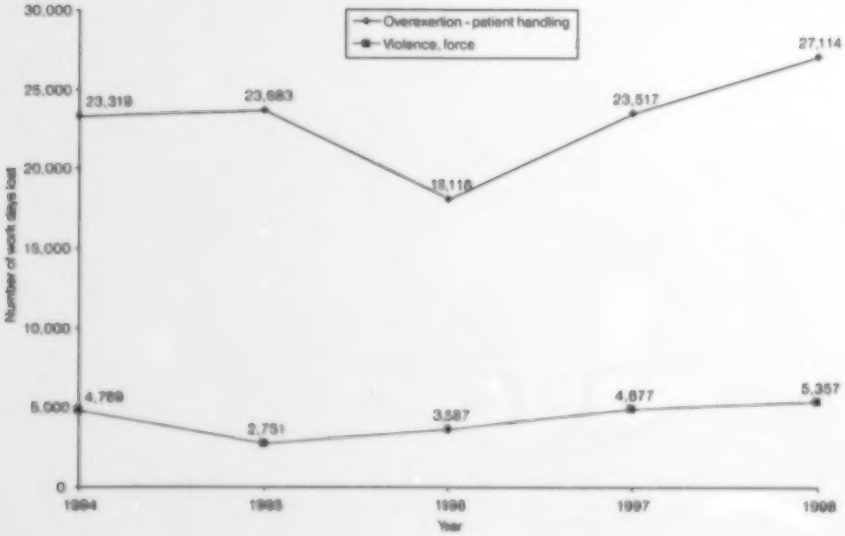
Total claims accepted for nurse aide, care aide, LPN from 1994 to 1998 = 3,986

The following line graphs show the yearly numbers of time-loss claims and the days lost for the top two accident types during this five-year period. These are overexertion—patient handling and violence or force, which together account for 72% of claims.

Claims for nurse aides, care aides, and LPNs, by accident type and year, 1994–98

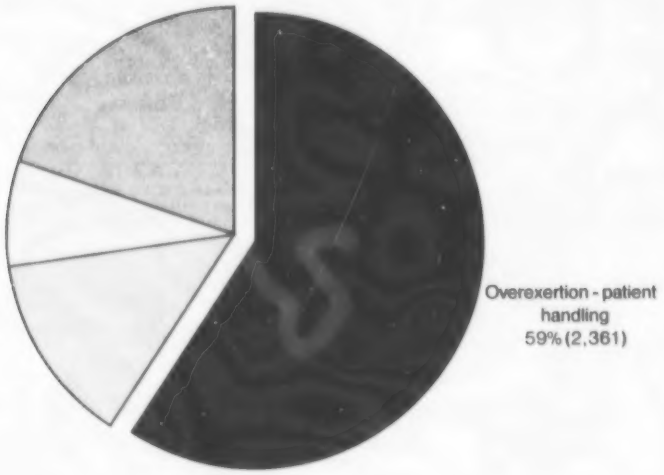


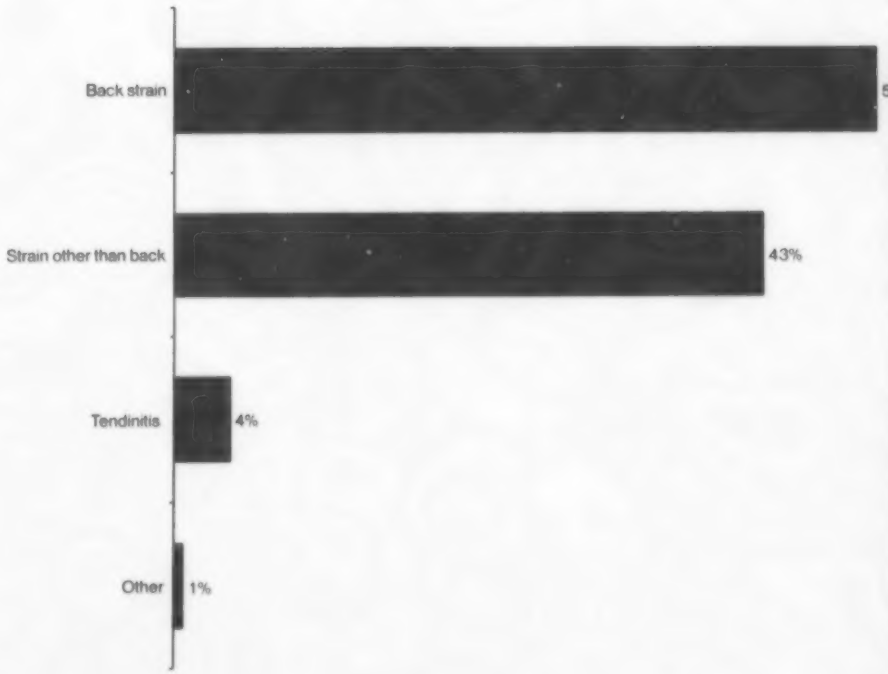
Days lost by nurse aides, care aides, and LPNs, by accident type and year, 1994–98



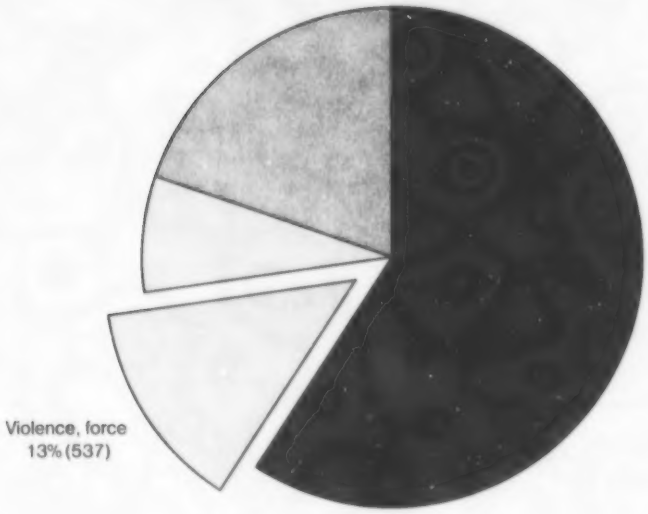
The bar graphs on pages 58–59 show the most common injury types resulting from overexertion—patient handling accidents and from violence or force.

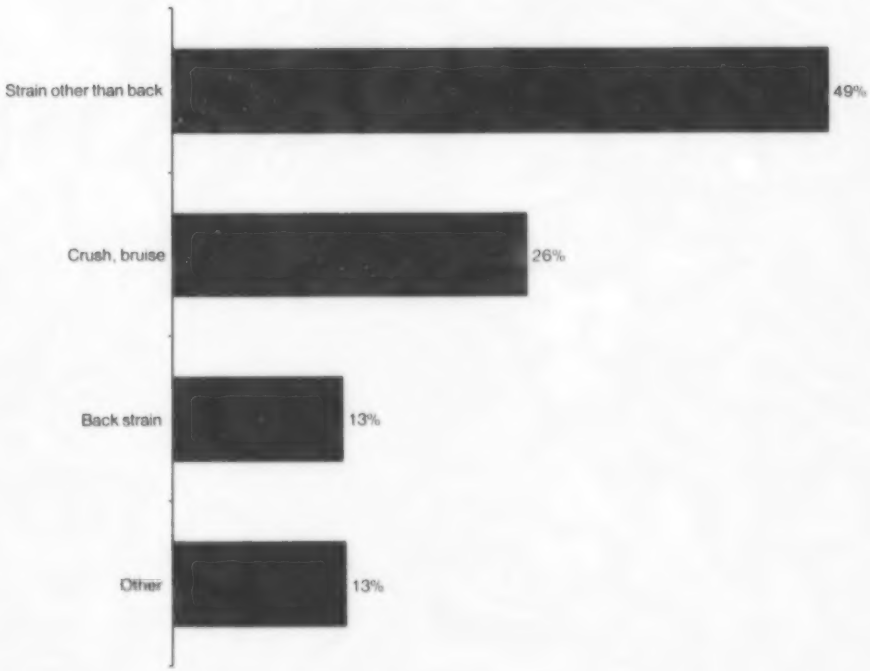
Injuries to nurse aides, care aides, and LPNs caused by overexertion—patient handling accidents, 1994–98





Injuries to nurse aides, care aides, and LPNs caused by violence or force, 1994–98





Food preparation workers and kitchen workers: Common accident types

There were 925 time-loss claims accepted from food preparation workers and kitchen workers in social services and related industries from 1994 to 1998. As shown in the pie graph below, most claims were due to the following types of accidents:

- Overexertion–material handling (30%)
- Fall on same level (17%)
- Struck-by (17%)
- Heat, cold (8%)

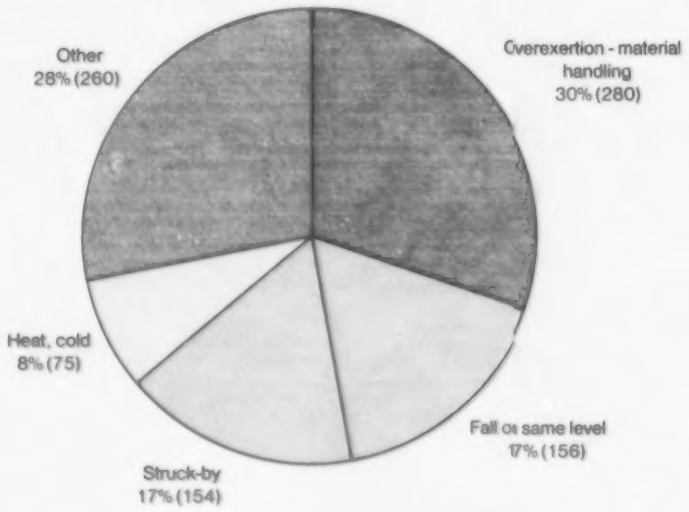
Accident types belonging to the "other" category include:

- Other body motion (non-repetitive motion) (7.8%, 72 claims)
- Strike against (7.1%, 66 claims)
- All else (13.2%, 122 claims)

Overexertion–material handling accidents accounted for 30% of the accidents. The most common injury types resulting from these accidents were:

- Back strain (47%)
- Strain other than back (44%)
- Tendinitis (8%)

Accident types for food preparation workers and kitchen workers, 1994–98



Total claims accepted for food preparation worker, kitchen worker from 1994 to 1998 = 925

Team approach reduces slip-and-fall injuries

Slip-related injuries in the kitchen at an extended care facility were clearly a problem. During 1996–97 there were eight falls resulting in four time-loss injuries. Time loss for those injuries exceeded 230 hours for the year.

"Ninety percent of the complaints I received from staff were about the floor, which was like a sheet of ice," says the nutritional services manager. "There were a lot of slips and falls."

After a few unsuccessful attempts to address the slip hazards, a committee consisting of kitchen staff, cleaning staff, the area manager, and a quality improvement co-ordinator tackled the problem using a team-based approach to identify root accident causes and solutions.

"In the past we would have put up a notice to wipe the floors more often and sent out a memo asking people to be more careful," says the team co-ordinator. "People thought that if we wiped the floors and they wore proper shoes they wouldn't fall. By getting into details, we found out exactly where people were falling and why."

The team looked at a range of issues, including footwear, floor surface characteristics, cleaning chemicals, kitchen traffic flow, and the floor-cleaning schedule. When the team first met, says the co-ordinator, its members thought they already had the answer: install a new floor. However, they decided not to jump to a solution without further analysis.

The team took a step back and discovered that although falls were occurring *in* the kitchen, it was not cooks who were falling. "We found that most of the kitchen workers who fell were using the kitchen production area as a shortcut," says the co-ordinator. Permanent barriers put an end to shortcuts and reduced the number of falls. The team also determined that the kitchen floor was being mopped during the busiest work period. Housekeepers were asked to adjust their kitchen cleaning schedule, and the chemicals used for floor cleaning were changed to result in better cleaning.

Slip-resistant footwear for staff was also investigated and was purchased for several workers. A bucket and squeeze-mop were made readily accessible for water clean-up.

A production chef on the team was impressed with both the process and the outcome. "We were having quite serious accidents, involving lots of time off," she says. "Today the number of slips and falls is down dramatically."

The nutritional services manager says that although the solutions seem like simple ones, the process itself was vital. Because staff developed the remedies, they understand what is being done and why. She says, "Typically management brings forth an edict about how to fix the problem, but staff often know best."

The results tell the story. There were no slip-and-fall accidents in the first 18 months after the solutions were implemented.

Home support workers, cleaners, and housekeepers: Common accident types

There were 614 time-loss claims accepted from home support workers, cleaners, and housekeepers in social services and related industries from 1994 to 1998. As shown in the pie graph below, most claims were due to the following types of accidents:

- Overexertion—material handling (38%)
- Fall on same level (13%)
- Overexertion—patient handling (13%)
- Other body motion (non-repetitive motion) (12%)

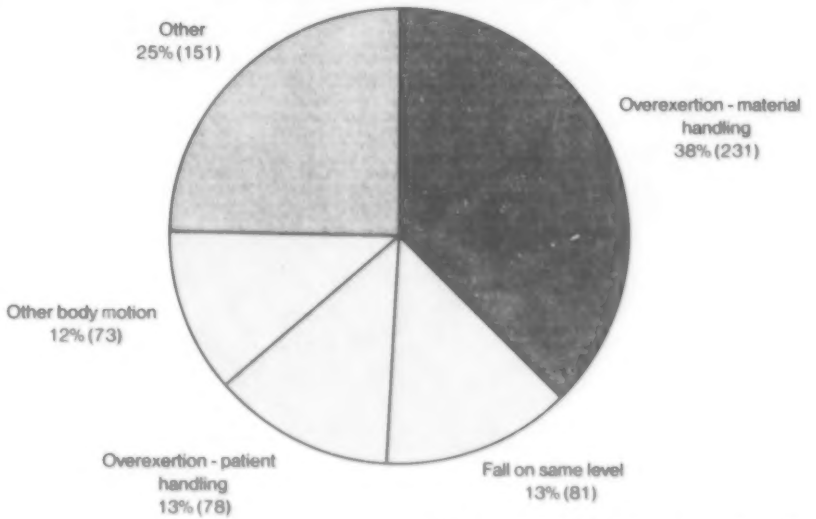
Accident types belonging to the "other" category include:

- Struck-by (5.2%, 32 claims)
- All else (19.4%, 119 claims)

Overexertion—material handling accidents accounted for 38% of the accidents. The most common injury types resulting from these accidents were:

- Back strain (47%)
- Strain other than back (44%)
- Tendinitis (7%)

Accident types for home support workers, cleaners, and housekeepers, 1994–98



Total claims accepted for home support worker, cleaner, housekeeper from 1994 to 1998 = 614

Registered nurses: Common accident types

There were 534 time-loss claims from registered nurses in social services and related industries from 1994 to 1998. As shown in the pie graph below, most claims were due to the following types of accidents:

- Overexertion–patient handling (52%)
- Violence, force (10%)
- Fall on same level (10%)
- Overexertion–material handling (7%)

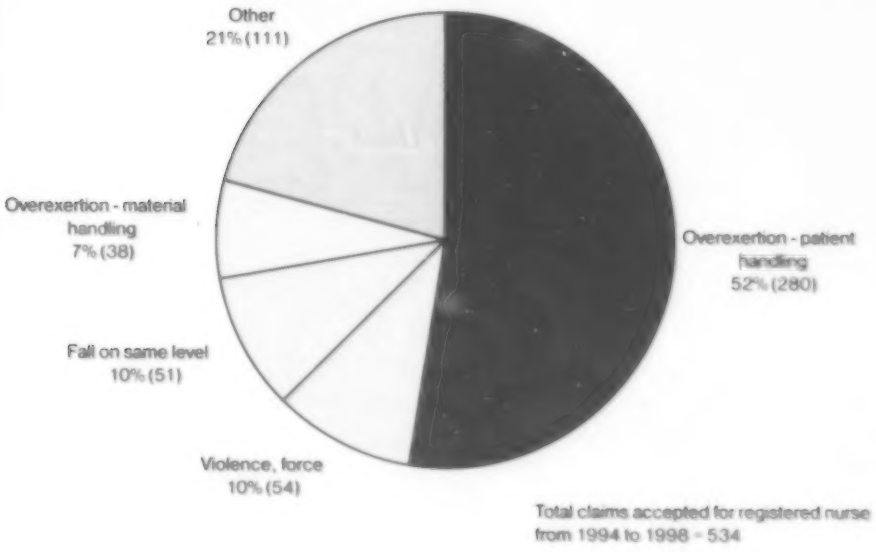
Accident types belonging to the "other" category include:

- Other body motion (non-repetitive motion) (6.7%, 36 claims)
- All else (14.0%, 75 claims)

Overexertion–patient handling accidents accounted for 52% of the accidents. The most common injury types resulting from these accidents were:

- Back strain (49%)
- Strain other than back (47%)

Accident types for registered nurses, 1994–98



For information about preventing occupational injury and disease, see page 65.

PREVENTING OCCUPATIONAL INJURY

AND DISEASE

Overview

The occupational injury and disease statistics presented in this report highlight the urgent need for effective health and safety measures in the B.C. health care industry. This section of the focus report provides general information and strategies for creating and maintaining a safe and healthy workplace. Several key elements in the prevention of workplace injury and disease are discussed:

- Commitment and leadership
- Effective occupational health and safety programs
- Maintenance and use of accurate records and statistics

Commitment and leadership

Health care employers are committed to delivering excellent patient health care. They, along with all workers, must also be committed to achieving and maintaining excellence in workplace health and safety. This commitment is needed in order to reverse the upward trend in the annual number of time-loss claims, days lost per claim, and claims costs for work-related injuries and diseases experienced by workers in the B.C. health care industry.

A National Research Council report[1] that examined key elements of successful safety programs revealed that although legislation contributes to improved safety, compliance alone does not result in an outstanding safety record. The report stated:

"The initiative to achieve and maintain excellent safety performance must come from management ... [since] they alone have the authority ... to establish the policies and priorities and to communicate them throughout their organizations. [As well], they alone have the authority to implement safety programs, commit resources, and reward their managers and employees for achieving the goals of those programs. The goals may not be achievable without the cooperation of employees, but only management has the authority to request of its employees the actions needed to realize these goals."

[1] *Committee on Underground Coal Mine Safety, National Research Council.* Toward Safer Underground Mines. *Washington, D.C.: National Academy Press, 1982.*

The report also emphasized that "the best safety program in the world, developed by the most committed management, will work only if it has the wholehearted support and active cooperation of [its workers]." This cooperation is important to the success of workplace health and safety programs. When employees (and management) demonstrate their commitment to health and safety by actively participating in health and safety committees and accident investigations and by finding solutions to health and safety hazards, the result is greater safety performance.

Management's commitment to health and safety can be demonstrated by:

- Setting prevention goals and measuring outcomes
- Allocating sufficient resources to develop and maintain an occupational health and safety program based on policies and procedures that reflect the organization's health and safety goals and values
- Assigning a health and safety representative with the authority to address problems
- Developing a system of accountability that makes everyone in the organization, both management and workers, responsible for workplace health and safety
- Providing sufficient education and training to workers and supervisors
- Providing adequate supervision of workers
- Ensuring that risk assessments are conducted where a risk of injury (for example, from overexertion or violence) or a risk of disease has been identified, and ensuring that control measures are implemented
- Conducting workplace inspections and making sure hazardous conditions are corrected
- Ensuring incidents, including accidents and near-misses, are investigated and corrective action implemented without delay
- Discussing health and safety activities and incident trends at management meetings
- Making regular health and safety meetings with workers a priority
- Monitoring health and safety strategies and activities

Occupational health and safety programs

Part 3 of the Occupational Health and Safety Regulation sets out the requirements for an occupational health and safety program for the prevention of workplace injury and disease. An occupational health and safety program is part of an employer's system for managing health and safety in the workplace.

Effective occupational health and safety programs prevent:

- Incidents that result in work-related injury or disease
- Near-misses (incidents that do not result in an injury or that result in a lesser injury than might be expected under the circumstances)
- The human impact of such incidents (for example, pain, suffering, and disability)
- The financial impact of incidents (for example, production downtime and the costs of hiring replacement workers or paying overtime)
- Damage to property, equipment, and the environment

An effective occupational health and safety program:

- Provides general direction to management, supervisors, and workers about their responsibilities and roles in ensuring a safe and healthy workplace
- Provides direction to those responsible for specific portions of the program
- Communicates health and safety policies and procedures
- Keeps lines of communication open so that workers can freely express their concerns about health and safety
- Helps ensure compliance with the Occupational Health and Safety Regulation

Employers with fewer than 50 workers may be permitted to have a less formal program than the one described on the next page. For more information, see Part 3, sections 3.1 and 3.2 of the Occupational Health and Safety Regulation.

Joint committee

Under new legislation effective October 1, 1999, a joint health and safety committee with worker and employer representatives is required in each workplace where 20 or more workers are regularly employed. Workplaces with 10 to 19 workers must have a designated worker health and safety representative. (A regular employee is a worker employed for at least one month.)

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Elements of an occupational health and safety (OHS) program

1. **Occupational health and safety policy:**
- States the employer's commitment to health and safety and the OHS program objectives
- Defines the responsibilities and roles of the employer, supervisors, and workers

2. **Regular inspections of premises:**
- Determine if the worksite, machinery, equipment, and work practices meet health and safety standards
- Identify unsafe conditions and acts with the potential to cause injury so that corrective measures can be taken
- Must be conducted at intervals that will prevent the development of unsafe working conditions

3. **Supplementary instructions (written safe work procedures):**
- Identify hazards and clarify what must be done to eliminate or minimize the hazards in order to comply with WCB requirements
- Guide and direct workers in the safe performance of their jobs
- Are used as training standards

4. **Management meetings:**
- Must be held regularly to review the OHS program activities and incident trends and to determine necessary courses of action

5. **Investigations of incidents:**
- Determine causes of accidents, near misses, injuries, and diseases so that corrective actions can be taken to prevent them from happening again
- Identify unsafe conditions, unsafe acts, and unsafe work procedures, and recommend solutions to prevent a similar occurrence of any of these

6. **Records and statistics:**
- Document the history of the OHS program and improvements made to it
- Provide a record of program activities such as orientation, training, inspections, incident investigations, and sampling
- Help identify trends, unusual conditions, and problem areas

7. **Joint health and safety committee:**
- Includes worker and employer representatives
- Identifies health and safety problems
- Recommends to management ways of improving health and safety activities
- Ensures that incident investigations and regular workplace inspections are carried out

8. **Instruction of workers:**
- Includes training (for example, orientation, crew talks, on-the-job training, and refresher training) to make workers proficient in performing their jobs safely
- Includes on-site direction and instruction by supervisors to ensure that workers perform their jobs safely

For more information

For more information on occupational health and safety programs, see the WCB publications *How to Implement an Effective Occupational Health and Safety Program* and *Effective Health and Safety Programs: The Key to a Safe Workplace and Due Diligence*. Ordering information is on page 77.

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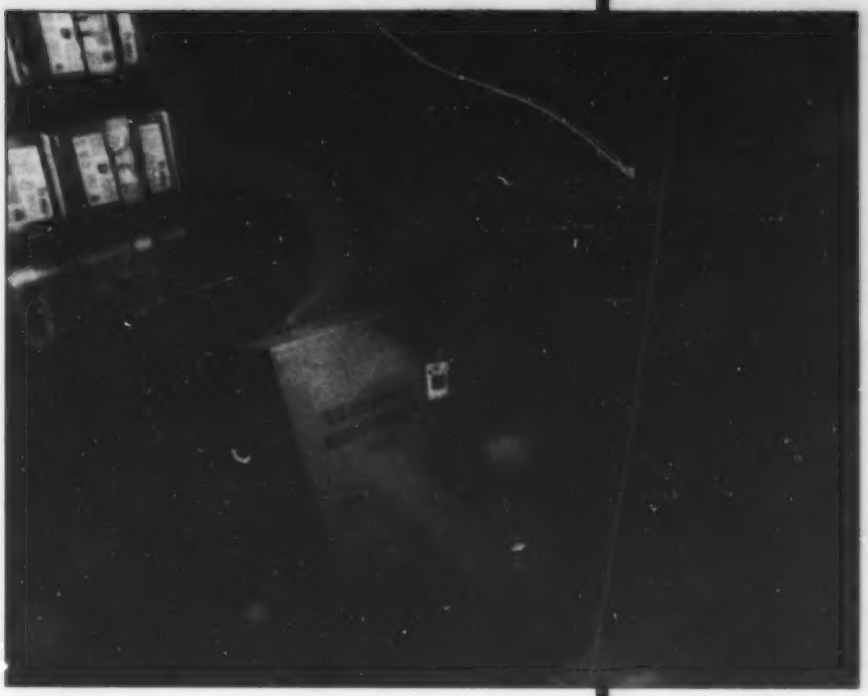
Preventing musculoskeletal injury (MSI)

Many of the ways we work—such as lifting, reaching, and repeating the same movements—can strain our bodies. Wear and tear on muscles, tendons, ligaments, and joints can injure the neck, shoulders, arms, wrists, legs, and back. This type of injury is called a musculoskeletal injury (MSI).

Overexertion is the most common type of accident in the health care industry, accounting for 55% of the accidents when both patient handling and material handling are included. The majority of injuries resulting from claims are MSI. (See graphs on pages 12–13.)

Incorporating ergonomics (the study of the relationship between workers and their working environment) into an occupational health and safety program can help prevent MSI. Part 4 of the Occupational Health and Safety Regulation states that employers are required to identify, assess, and control factors in the workplace that may expose workers to the risk of MSI. This can include risks from handling patients, residents, materials, equipment, and furniture.



Risk factors can include the physical demands of work activities as well as room and furniture layout and the size and shape of objects being handled.

See sections 4.46 to 4.53 of the Regulation for more detail on the WCB ergonomic requirements. For more information about preventing MSI, contact your local WCB Prevention Office.

Violence prevention

From 1994 to 1998, acts of violence or force accounted for 2,460 time-loss claims in the health care industry as a whole. This amounted to almost 7% of the total number of time-loss claims.

Employers are required to minimize the risk of injury to workers from violence arising out of their employment by:

- Identifying and assessing areas of risk
- Establishing policies, procedures, and work environment arrangements to eliminate or minimize such risk to workers
- Establishing procedures for reporting, investigating, and documenting incidents of violence
- Informing workers of the nature and extent of the risk of violence
- Providing instruction about violence prevention and reporting incidents
- Investigating and reporting incidents of violence
- Taking corrective action in response to incidents of violence

Many health care facilities have chosen to incorporate violence prevention strategies in a dedicated violence prevention program, which forms a subprogram within their overall occupational health and safety program.

What is violence in the workplace?

The Occupational Health and Safety Regulation defines violence as "the attempted or actual exercise by a person, other than a worker, of any physical force so as to cause injury to a worker, and includes any threatening statement or behaviour which gives a worker reasonable cause to believe that he or she is at risk of injury" (Part 4, section 4.27).

Example: A nursing home resident entered another resident's room and a fight erupted between the two residents. A care aide was bitten on the wrist and scratched on the face while trying to separate them.

For more information

For more information about how to set up a violence prevention program, see the following WCB publications:

- *Take Care: How to Develop and Implement a Workplace Violence Prevention Program*
- *Gently into the Night: Aggression in Long-Term Care*

To order these publications, contact the WCB Publications and Videos section (see page 77).

Exposure control plans

Several sections of the Occupational Health and Safety Regulation require employers to establish an exposure control plan. The elements of an exposure control plan include strategies for risk identification, assessment, and control, as well as education and training, to ensure that workers are not exposed to harmful levels of hazardous substances or energy, such as:

- Biohazardous material (for example, a pathogen in human blood)
- Cytotoxic drugs (for example, drugs used in chemotherapy)
- Ionizing and non-ionizing radiation
- Asbestos
- Heat stress

Elements of an exposure control plan are listed in Part 5, section 5.54(2) of the Regulation.

Workplace Hazardous Materials Information System (WHMIS)

Employers are required to establish and maintain an effective WHMIS program to ensure the safe storage, handling, use, and disposal of a variety of hazardous materials. For more detailed information, see Part 5, sections 5.3 to 5.19 of the Occupational Health and Safety Regulation.

Protective equipment program

Eye, face, and respiratory protection, and protective gloves and aprons, are sometimes required in health care settings to protect workers from chemical exposures. Where such personal protective equipment is required, employers must implement an effective protective equipment program. Program requirements are specified in Part 8, section 8.5 of the Occupational Health and Safety Regulation.

Activating an exposure control plan

A nurse withdrew a needle from a patient and tried to place the used syringe in the sharps container. The container lid was closed and the needle "bounced back" at the nurse, piercing her abdomen. The hospital's exposure control plan was activated. The nurse received immediate first aid and medical attention, including an assessment of the risk of infection, blood testing, and follow-up with drug therapy to reduce the risk of infection. An accident investigation was also conducted and documented.

Emergency preparedness

Emergency preparedness and response (for example, in case of a fire or an uncontrolled chemical spill) are important parts of any occupational health and safety program for health care facilities such as hospitals, nursing homes, and group homes. The program must address procedures for emergency evacuation and response. For more information, see Part 4, sections 4.13 to 4.18 of the Occupational Health and Safety Regulation.

First aid

Part 33 of the Occupational Health and Safety Regulation specifies the first aid equipment, supplies, facilities, and services required to provide workers with prompt first aid.

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The importance of records and statistics

Anyone trying to prevent workplace injuries and diseases needs accurate and complete records and statistics. Having the right records and statistics helps everyone make more informed decisions about health and safety matters and determine whether prevention goals are being met. In general, the most useful injury and disease statistics are those that pinpoint accident and injury types, hazards, tasks, and conditions—specifically by location and by occupation, if possible.

Effective occupational health and safety programs in the health care industry rely on accurate records such as:

- Risk assessment reports
- Hazard investigation reports
- Inspection reports
- First aid records
- Incident investigation reports (from near-misses to serious injuries)
- Injury and disease claims forms
- Education and training records
- Hepatitis B vaccination records

Maintaining records and statistics is a required element of occupational health and safety programs because it enables employers, managers, and joint health and safety committees to answer important questions. For example:

- How many time-loss injuries have there been this month? This year? How do these counts compare with those for the same periods last year?
- What are the most common injury types? Accident types? Causes? Body parts injured?
- What is the injury rate (the number of time-loss claims per 100 person-years of employment) for our organization? How does this rate compare with those of other employers who provide similar services?
- What are our claims costs so far this year?
- Have incident investigations been completed for all recordable incidents?
- Have workplace inspections been completed for each month? Have all deficiencies been corrected?
- Have all new workers received a health and safety orientation?

The value of first aid records

First aid records illustrate the importance of maintaining records and statistics. Detailed reports of first aid treatment provide employers, joint committees, and worker representatives with information they can use to:

- Identify the type and severity of injuries in the workplace
- Identify work areas and practices that may be causing injuries
- Identify potential problems that require closer examination during workplace inspections
- Determine corrective actions
- Assess the effectiveness of first aid and safety programs and safe work procedures

Employers are required to keep a record of all workplace injuries and manifestations of disease that have been reported or treated, whether or not the injuries lead to further treatment or the filing of a time-loss claim. In workplaces that are required to have a first aid attendant, it is the attendant's responsibility to keep records of all first aid treatments. These records and reports must be clear, concise, and correct. Accurate and factual accounts of an injured or ill worker's condition, from the time of the accident until arrival at a medical facility, are also essential. If some of the information needed is not available at the time of the accident, it must be gathered and recorded as soon as possible afterward. When information on workplace injuries and illnesses is not available or is incorrect, it is more difficult to identify problems and take corrective action.

7. RESOURCES

WCB resources

Prevention Information Line

The WCB Prevention Information Line answers questions on:

- Health and safety requirements
- Employer and worker responsibilities under the *Workers Compensation Act*
- General safety and hygiene topics
- First aid requirements
- Reporting an accident or other incident

You can also call to report workplace health and safety concerns. Anonymous calls are accepted.

During business hours, call 604 276-3100 or call toll-free 1 888 621-SAFE (7233). For after-hours and weekend emergencies, call 604 273-7711.

Electronic reporting of incidents and injuries

Employers have a number of options for reporting incident and injury information to the WCB electronically. Each option provides employers with an alternative to completing the paper version of Form 7 (Employer's Report of an Accident), Form 7A (First Aid Report), and the Accident Investigation Report. Electronic reporting offers employers a number of advantages, including improved statistical reporting and better communication with the WCB.

Electronic reporting options include:

- EmployerConnect (the WCB's Internet-based reporting system)
- Third-party software products
- Specifications for developing systems in-house
- Third-party service providers
- AIRS (Accident and Injury Reporting System)

For more information about these options, contact the electronic reporting help desk by phone at 604 276-3135 or 1 888 855-2477, or by e-mail at erhelp@wcb.bc.ca.

Publications and videos

The WCB is one of North America's leading publishers of workplace safety materials. Many brochures, posters, and booklets are free to B.C. workers and employers. Some videos are available for purchase or loan.

The following WCB publications may be helpful to employers and workers in the health care industry:

- *Back Talk: An Owner's Manual for Backs*
- *Dealing with "Latex Allergies" at Work*
- *Effective Health and Safety Programs: The Key to a Safe Workplace and Due Diligence*
- *Gently into the Night: Aggression in Long-Term Care*
- *HIV/AIDS, and Hepatitis B and C: Preventing Exposure at Work*
- *How to Implement an Effective Occupational Health and Safety Program*
- *How to Make Your Computer Workstation Fit You*
- *Laboratory Health and Safety Handbook*
- *Safety on the Job Is Everyone's Business*
- *Take Care: How to Develop and Implement a Workplace Violence Prevention Program*
- *WHMIS at Work*

To receive the WCB publications catalogue, WCB video catalogue, or any publications or videos listed in the catalogues, contact the Publications and Videos Section:

Publications and Videos Section
Workers' Compensation Board of B.C.
6711 Elmbridge Way
Richmond BC
Phone: 604 276-3068
Fax: 604 279-7406
Toll-free: 1 800 661-2112, local 3068

Mailing address:
Workers' Compensation Board of B.C.
PO Box 5350 Stn Terminal
Vancouver BC V6B 5L5

E-mail: pubvid@wcb.bc.ca

WorkSafe Magazine

The WCB magazine *WorkSafe* (formerly called *Prevention at Work*) provides health and safety news for the employers and workers of British Columbia. It is published bi-monthly.

For your free subscription to this magazine, call 604 231-8690. Outside the Lower Mainland, call toll-free 1 800 661-2112, local 8690.

Publications on the Web

The Occupational Health and Safety Regulation and some other WCB publications are available at the WCB Web site: www.worksafebc.com.

WorkSafe Education Network

To increase the accessibility of health and safety education and training, the WCB has formed partnerships with B.C. educational institutions to provide community-based education courses. Most college campuses in B.C., the British Columbia Institute of Technology, the University of Northern B.C., and various school districts offer WorkSafe education courses. The courses available at time of publication are:

- Occupational Health and Safety in Small Business
- Hazard Recognition and Control
- Investigating and Controlling Sprains and Strains
- Occupational Health and Safety Committee Training
- Supervisor Safety Management
- Preventing Workplace Violence

Other courses are being developed. For more information, or to register for a WorkSafe course, call the campus in your area or call the WCB at 604 276-3100 or call toll-free 1 888 621-SAFE (7233).

WCB library open to the public

The WCB library maintains a comprehensive collection of health and safety publications. You can browse information at the library or borrow publications through your local library's interlibrary loan service.

6951 Westminster Hwy
Richmond BC V7C 1C6
Phone: 604 231-8450
Fax: 604 279-7608
Toll-free: 1 800 661-2112, local 8450

Open 8:30 to 4:30, Monday to Friday

Employers' Advisers

The Employers' Advisers office is a branch of the Ministry of Labour. It is independent of the WCB. Employers' advisers provide assistance and advice to employers on workers' compensation legislation, decisions, appeals, and policies. Advisers conduct educational seminars for employers on many topics such as occupational health and safety requirements, claims management, and assessments.

Richmond
Employers' Advisers,
Compensation Advisory Services
4003 - 8171 Ackroyd Road
Richmond BC V6X 3K1
Phone: 604 660-7253
Fax: 604 660-7498
Toll-free: 1 800 925-2233

Prince George
Toll-free: 1 888 608-8882

Victoria
Toll-free: 1 800 663-8783

Web site
www.labour.gov.bc.ca/eao

Workers' Advisers

The Workers' Advisers office is also a branch of the Ministry of Labour, independent of the WCB. Workers' advisers provide assistance and advice to workers who are having problems with WCB claims.

Richmond
Workers' Advisers,
Compensation Advisory Services
3000 - 8171 Ackroyd Road
Richmond BC V6X 3K1
Phone: 604 660-7888
Fax: 604 660-5284
Toll-free: 1 800 663-4261

Kamloops
Toll-free: 1 800 663-6695

Nanaimo
Toll-free: 1 800 668-2117

Victoria
Toll-free: 1 800 661-4066

Prince George
Toll-free: 1 800 263-6066

Web site
www.labour.gov.bc.ca/wab

Occupational Health and Safety Agency for Healthcare in British Columbia

The mandate of the Occupational Health and Safety Agency for Healthcare in British Columbia (OHSAH) is to reduce workplace injuries and illness in health care workers and to get injured workers back on the job quickly and safely. OHSAH's mission is to:

- Assist the health care community to develop guidelines and programs designed to promote better health and safety practices and safe, early return-to-work
- Promote pilot programs and facilitate sharing best practices
- Develop new measures to assess the effectiveness of programs and innovations in this area

OHSAH
#301 – 1195 West Broadway
Vancouver, BC V6H 3X5
Phone: 604 775-4034
Fax: 604 775-4031
Web site: www.ohsah.bc.ca

WCB Offices

Visit our Web site at www.worksafebc.com

Abbotsford
2774 Trethewey Street V2T 3R1
Phone 604 276-3100
1 800 292-2219
Fax 604 556-2077

Burnaby
450 – 6450 Roberts Street V5G 4E1
Phone 604 276-3100
1 888 621-7233
Fax 604 232-5969

Coquitlam
104 – 3020 Lincoln Avenue V3B 6B4
Phone 604 276-3100
1 888 967-5377
Fax 604 232-1946

Courtenay
801 – 30th Street V9N 8G6
Phone 250 334-8745
1 800 663-7921
Fax 250 334-8757

Cranbrook
100 – 7th Avenue S. V1C 2J4
Phone 250 417-7934
1 800 663-4912
Fax 250 417-7972

Kamloops
321 Battle Street V2C 6P1
Phone 250 371-6003
1 800 663-3935
Fax 250 371-6031

Kelowna
110 – 2045 Enterprise Way V1Y 9T5
Phone 250 717-4313
1 888 922-4466
Fax 250 717-4380

Nanaimo
4980 Wills Road V9T 6C6
Phone 250 751-8040
1 800 663-7382
Fax 250 751-8046

Nelson
524 Kootenay Street V1L 6B4
Phone 250 352-2824
1 800 663-4962
Fax 250 352-1816

North Vancouver
100 – 126 East 15th Street V7L 2P9
Phone 604 276-3100
1 888 875-6999
Fax 604 232-1500

Prince George
1066 Vancouver Street V2L 5M4
Phone 250 561-3700
1 800 663-6623
Fax 250 561-3710

Surrey
100 – 5500 152nd Street V3S 8E7
Phone 604 276-3100
1 888 621-7233
Fax 604 232-7077

Terrace
4450 Lakelse Avenue V8G 1P2
Phone 250 615-6605
1 800 663-3871
Fax 250 615-6633

Vernon
3100 – 35th Avenue V1T 8Y8
Phone 250 545-1125
1 800 663-4452
Fax 250 558-5243

Victoria
4514 Chatterton Way V8X 5H2
Phone 250 881-3418
1 800 663-7593
Fax 250 881-3482

Head Office
6951 Westminster Hwy
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V7C 1C6

Mailing Address:
PO Box 5350 Stn Terminal
Vancouver, BC V6B 5L5
Phone 604 273-2266
Toll Free 1 888 621-SAFE (7233)

After Hours Safety & Health Emergency
604 273-7711